Caddell's Laser and Electrolysis Clinic
Confidential Medical History – Laser Hair Removal Consultation

Last Name:_____First Name:_____MI:___

Address:_____

City:_____State:_____Zip:_____DOB:_____

Home Phone:_____May we leave a message at home? Yes/No

Work Phone:_____May we leave a message at work? Yes/No

Cell Phone:_____May we leave a message on cell? Yes/No

Email:_____May we put you on our mailing list? Yes/No

Pronoun(s) of choice: _____

How did you hear about us?_____

MEDICAL HISTORY

CIRCLE ANY MEDICATIONS OR PROBLEMS YOU HAVE FROM THE LIST BELOW:

Antibiotics	Blood Thinners	Diuretics	Keloid Scars	Blood Clots
Accutane	Canker Sores	Eczema	Leukemia	Vascular Disease
Acne	Cold Sores	Latex Allergies	Metal Pins	HIV
Aspirin	Contacts	Heart Conditions	Moles	Multiple Sclerosis
Birth Control	Diabetes	Hepatitis	Vitiligo	Immunosuppression
Psoriasis	Skin Infection	Skin Cancer	Pacemaker	Cancer
Anemia	Rheumatoid Arthritis	High Blood Pressure	Bleeding Disorders	Gold Therapy
Blood Disease	Collagen Vascular Disease	Hormones	Acute or Chronic Kidney Disease	

List any Present Illness:_____

List any Chronic Disease:_____

List any Past Surgical History:_____

Have you experience post inflammatory hyper pigmentation (brown pigmentation in the skin)? Yes/No

Please list your Present Medication (include any herbal medication(s)):_____

_____

Please list any allergies to medication or materials:_____

Female Client Medication Information:

Are you pregnant?	Yes/No	Do you have polycystic ovarian syndrome:	Yes/No
Are you breastfeeding?	Yes/No	Do you have endocrine problems at present?	Yes/No
Are you in menopause?	Yes/No	Are you on birth control or hormone medication?	Yes/No
Regular periods?	Yes/No	Have you ever had Gold Therapy?	Yes/No

Other:_____

I acknowledge the above medical history is thorough, correct and accurate to the best of my knowledge.

Signature:_____Date:_____

Printed Name:_____

Provider Signature:_____Review By:_____

Patient Name:_____

Caddell's Laser Clinic - Confidential Medical History, *Page 2*

LASER HAIR REMOVAL

Desired Treatment Areas: (Please circle)

Abdomen	Full Legs	Hairline	Nose
Under Arms	Ears	Lip: Upper/Lower	Private Areas
Forearms	Eyebrows	Breasts	Neck
Upper Legs/Thigh	Back	Chin	Hands/Fingers
Lower Legs	Chest	Feet/Toes	Bikini

Other:_____

CURRENT EVALUATION OF SKIN/HAIR

Previous Treatments		Temporary Methods	
Electrology	Yes/No	Shaving	Yes/No
Laser	Yes/No	Tweezing	Yes/No
Electric Tweezers	Yes/No	Depilatories	Yes/No
None		Waxing	Yes/No

Skin Type

How Do You Tan? (Check one)

- Very Good ☐
- Fairly Good ☐
- Not Good ☐
- Burn Easily ☐

How Do You Heal? (Check one)

- Very Good ☐
- Fairly Good ☐
- Slow Healer ☐

Office Use Only

Fitzpatrick Skin Type

_____

Initials: _____

Last Exposure to Sun or Tanning Bed: Date:_____

Last Use of Self-Tanning Product: Date:_____

Do you have any interest in our other services? (Check all that apply)

Spider Vein Treatment ☐	Laser Tattoo Removal ☐	Facial Vein Treatments ☐
Microdermabrasion ☐	Chemical Peels ☐	Facials ☐
Electrolysis ☐	Leg Vein Treatment ☐	Brown or Red Spots ☐
Broken Capillaries ☐	Skin Tag Removal ☐	Aesthetic Services ☐

I am aware that my initial medical evaluation is performed by a Staff Physician Assistant (PA) or Nurse Practitioner (ARNP) who will review my medical history and initiate or review treatment. Treatments may then be delegated to and performed by Staff Nurses and Estheticians. This is in compliance with the State of Washington laws regarding the use of laser for hair removal.

Signature:_____Date:_____

Printed Name:_____

Provider Signature:_____Reviewed By:_____