Evergreen LASER
Laser Hair Removal & Med Spa

INTAKE FORM

Patient Name: ______________________________ Today's Date: ______________
(FIRST) (LAST)

In order to provide you with the most appropriate laser treatment, we need you to complete the following questionnaire. All information is strictly confidential.

Your Date of Birth: ________________ Age: ________ Gender at Birth: (circle) M F

Address: ______________________________________ Apartment # ________

City: ________________________ State: ______________ Zip: __________

Phone Number: ________________________ E-mail: ______________________

How did you hear about us? ______________________________

Maritial Status (circle): *Single* *Married* *Divorced* *Widowed*

Occupation: ______________________________

(Note: Ethnicity, national origin and race may affect how skin reacts to laser / IPL)

Ethnicity (circle): *Caucasian* *Hispanic* *African American* *Asian* *Middle Eastern* *Pacific Islander* *Other* ____________________

Emergency Contact Name: ______________________________

Phone Number: ______________________________ Relationship: ____________

Medical History

Are you currently under the care of a physician? YES ☐ NO ☐
If yes, for what? ______________________________
____

Are you currently under the care of a Dermatologist? YES ☐ NO ☐
If yes, for what? ______________________________
____

Do you have a history of erythema abigne, which is a persistent skin rash produced by prolonged or repeated exposure to moderately intense heat or infrared irritation? YES ☐ NO ☐

Any other health problems? ____________________

Do you have any of the following Medical Conditions:

	YES	NO
Cancer	☐	☐
Diabetes	☐	☐
High Blood Pressure	☐	☐
Arthirtis	☐	☐
Herpes	☐	☐
Frequent Cold Sores	☐	☐
Skin Disease/Skin Lesions	☐	☐
Keloid Scarring	☐	☐
Hepatitis	☐	☐
Blood Clotting Abnormalities	☐	☐
HIV/AIDS	☐	☐
Seizure Disorder	☐	☐
Hormone Imbalance	☐	☐
Thyroid Imbalance	☐	☐

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Medications & Allergies

Are you on any mood altering or anti-depression medication? YES ☐ NO ☐
If yes, for what? ______________________

Have you ever used Accutane? YES ☐ NO ☐
If yes, when did you last use it? ______________________

What oral medications are you presently taking?
____

What herbal supplements do you use regularly?
____

What topical medications or creams are you currently using?
☐ Retin-A® ☐ Other: ______________________

Do you have any of the following Allergies?:

	YES	NO
Food	☐	☐
If yes, explain ______________________		
Latex	☐	☐
Aspirin	☐	☐
Lidocaine	☐	☐
Hydrocortisone	☐	☐
Hydroquinone or skin bleaching agents	☐	☐

FEMALE PATIENTS	YES	NO
Are you pregnant?	☐	☐
Trying to become pregnant?	☐	☐
Are you breastfeeding?	☐	☐
Are you using contraception?	☐	☐

History

	YES	NO
Have you had any recent tanning or sun exposure that changed the color of your skin?	☐	☐
Have you recently used any self-tanning lotions or treatments?	☐	☐
Do you form thick or raised scars from cuts or burns?	☐	☐
Do you have Hyperpigmentation (darkening of the skin) or marks after physical trauma?	☐	☐
Do you have Hypopigmentation (lightening of the skin) or marks after physical trauma?	☐	☐
Have you ever had laser hair removal?	☐	☐

Have you used any of the following hair removal methods in the past four weeks?

☐ Shaving ☐ Waxing ☐ Electrolysis ☐ Plucking ☐ Tweezing ☐ Threading ☐ Depilatories

I have provided complete and accurate contact and medical information and that I read, fully understand, and completely agree with the HIPAA Patient Consent, the Appointment Policy, and the Financial Responsibility Policy. I understand that results may vary from any and all procedures and treatments and that there are absolutely **NO REFUNDS**. ☐ ______________
Initial

I certify that the preceding medical, personal, and skin history statements are true and correct and given on "today's date" stated on pages one of two on this intake form. I am aware that it is my responsibility to inform the technician, esthetician, therapist, doctor, or nurse of my current medical or health conditions and update this history. Recent medical history is essential for the caregiver to execute appropriate treatment procedures.

______________________ Patient Name (print)

______________________ Patient Signature *Signature Of Guardian (if Minor)*