



# Laser Patient Profile

NP  RT  RS  O  S  QB  N

Last Name: \_\_\_\_\_ First: \_\_\_\_\_ Initial: \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ Postal Code: \_\_\_\_\_

Telephone: Home ( ) \_\_\_\_\_ Work ( ) \_\_\_\_\_

Cellular: ( ) \_\_\_\_\_ OHIP Number: \_\_\_\_\_

Date of Birth: Day \_\_\_\_\_ Month \_\_\_\_\_ Year \_\_\_\_\_ Age: \_\_\_\_\_ Email: \_\_\_\_\_

Occupation: \_\_\_\_\_ Are you pregnant, breastfeeding or trying to conceive? \_\_\_\_\_

Family Physician: \_\_\_\_\_ City: \_\_\_\_\_

How may we remind you of your appointment?  Email OR  No Reminder Please

How did you hear about us? MD Referral  Internet  Radio  Facebook  Instagram   
 Referred by friend  Who? \_\_\_\_\_ Magazine  Tradeshow

## PAST MEDICAL HISTORY

Past Medical History (ie. Cancer, HIV, Hep. C, Diabetes, Surgery etc.) \_\_\_\_\_

Current Medications including vitamins (dose not required) \_\_\_\_\_

Are you currently taking immunosuppressant medication?  YES  NO

Allergies (Include meds, type, med treatments and environmental) \_\_\_\_\_

**HAVE YOU EVER HAD ANY OF THE FOLLOWING SKIN CONDITIONS:**  Cold Sore (Herpes)  Melasma  Rosacea

Acne  Psoriasis  Eczema  Hyper/hypo pigmentation  Keloid (thick) scarring  Warts  Thyroid Imbalance

## HAVE YOU PREVIOUSLY HAD?

Botox  Fillers  Facial Laser  Facial Peel  Skin Tightening  
 Facial Surgery  Facial Trauma  Chronic Headaches  Permanent Fillers/Implants  Tattoo  
 Hyperhidrosis  Microdermabrasion  Dermabrasion  Laser Hair Removal  Polycystic Ovaries

## YOUR CONCERNS:

Face  Lips  Unwanted Hair  Red Spots  Rosacea  
 Frown Lines  Headaches  Brown Spots  Fat Reduction  Excessive Sweating  
 Wrinkles  Uneven Skin Surface  Loose Skin  Spider/Varicose Veins  Skin Cancer

## ARE YOU CURRENTLY USING THE FOLLOWING SKIN CARE PRODUCTS?

Accutane  Retina A/Retinol  Alpha Hydroxy Acids  Topical/Oral Steroids  Glycolic Acids

## AREAS FOR HAIR REMOVAL:

Bikini  Brazilian  Legs  Under Arms  
 Back  Chest  Upper Lip/Chin  Face  Other \_\_\_\_\_

## IN THE LAST 6 WEEKS HAVE YOU:

Waxed or plucked the area to be treated  Suntanned  
 Used antibiotics, Accutane, steroids, Retin A, Alphahydroxyl Creams

*These products can cause reactions with lasers.*

***You may not be permitted to have some laser treatments if you have a recent tan or are currently taking specific medications.***

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Laser Technician Signature