Alora Health Spa

Patient Information - Laser Hair Removal

Name: _____ Date of Birth: __/___/_____
Phone: _____ Email: _____
How did you find us? _____

To provide care that is both safe and effective please review the following conditions. If any of the following conditions apply to you, Laser Hair Removal would not be advised. A doctor's note may be required to proceed with treatment.

Any active skin condition in the treatment area, sores psoriasis, eczema, dermatitis, or rash.
Current or history of cancer, especially of skin cancer or pre-malignant moles
History of diseases stimulated by heat Herpes Simplex
History of skin disorders Keloid scarring/Abnormal wound healing
Impaired Immune system HIV/AIDS
Pregnancy/Nursing
Sunburned or freshly tanned skin.
Use of Accutane within 6 months
Vitiligo

Existing or Recent Illness: _____
_____
Hospitalization/Surgery: _____
_____
Please list any medications you are currently using (Topical, Ingestible, or Injectable):
_____
_____
Allergies: _____

Have you had any of the following treatments in the last 3 months? ❑Chemical Peel ❑Laser Peel ❑BOTOX ❑Fillers ❑Glycolic Peel ❑Microdermabrasion ❑Cosmetic Surgery
Are you using Rogaine, Propeci, Minoxidil? ❑Yes ❑No
Are you using steroids? ❑Yes ❑No
Are you taking any herbal or vitamin supplements? ❑Yes ❑No
Do you use tobacco? ❑Yes ❑No
Do you consume more than two alcoholic beverages per day? ❑Yes ❑ No

Have you ever had laser treatments or Electrolysis? ❑Yes ❑No
Procedures/Areas treated: _____
_____
Number of Treatments: _____
When was your last treatment? _____

Method of depilation? ❑Waxing ❑Shaving ❑Tweezing ❑Threading

Allergic reaction? ❑Redness ❑Swelling ❑Itching ❑Scaling

What happens if you stay in the sun too long? ❑Painful redness ❑Blistering and peeling ❑Blistering followed by peeling ❑Burn sometimes followed by peeling ❑Never burns

To what degree do you tan?
❑Hardly or not at all ❑Light color tan ❑Reasonable tan ❑Tan very easy ❑Turn dark quickly

When did you last expose your body to the sun?
❑More than 3 months ❑2-3 months ❑1-2 months ❑Less than a month ❑Less than 2 weeks

I consent to before, during and after the procedure(s) the taking of photographs to be part of my patient profile that may be used for educational and marketing purposes without disclosing my identity nor exposing my face. ❑Yes ❑No Initial Here: _____

In case of emergency, whom should we call? Name: _____
Phone: _____ Relationship: _____

I give consent to undergo Laser Hair Removal treatments provided by Alora Health Spa. I understand and I agree that this constitutes full disclosure and that it supersedes any previous verbal or written disclosures. I understand that withholding information or providing misinformation may result in contraindication and/or irritation to the skin from treatments received. I am aware that it is my responsibility to inform my laser specialist of my current medical or health conditions and to update this history. The treatments I receive here are voluntary and I release Alora Health Spa and/or laser specialist from liability and assume responsibility thereof.

Signature: _____ Date: _____

OFFICE USE ONLY

Notes: _____
_____
_____
_____
_____
_____