IPL Client Medical History Information

Name: ___________________________ Birth Date: _____ /_____ /_____ Age: _______

Address: ____ Sex: M / F

City: _________________________________ Post Code: _________________

Home: (____)_______________ Work: (____) ____________ Mobile: (____) ___________

E-mail: ____

Emergency Contact: _____________________ Telephone: (_____) ___________________

Allergies: ____

How did you hear about us? ____

Please put a check mark next to a past or current medical condition or treatment:

Medical History:

___ Lupus or other auto-immune deficiency
___ Pregnant
___ Graves Disease (Hyperthyroidism) Hashimoto's Disease (Hypothyroidism) and/or Treatment with Thyroxine
___ Bleeding abnormalities
___ Blood thinning medication (except low dose Aspirin)
___ Keloid or very thick scarring
___ Psoriasis or Vitiligo
___ Pulmonary embolism/blood clot
___ Leg ulcer or Phlebitis
____ Rheumatoid Arthritis "Gold" Therapy
___ Photodynamic Therapy (PDT) within last 3 months
___ Chemotherapy or Radiotherapy within the last 3 months

___ Herpes simplex (Cold Sores) or fever blisters
___ Diabetes
____ Epilepsy
___ Scars that turn white or brown
___ Dark spots after pregnancy or after skin injury
___ HIV
___ Hepatitis
___ Waxing/Plucking/Electrolysis within last 6 weeks
___ Hirsutism / Polycystic Ovarian Syndrome
___ Transplant Anti-Rejection Drugs
___ Treatment with Accutane® in the last 6 months
___ Chemical Peels, Dermabrasion, Laser Skin Resurfacing or Face Lift
___ Botox and/or Fillers in the treatment area within the last 2 months

Please list any other medications or herbal supplements that you are currently taking:

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____ ____________________
Client Signature Date