Laser Hair Removal Questionnaire

Patient name:_____

1. What area(s) are you interested in treating?

☐ scalp ☐ neck ☐ bikini line ☐ under arms ☐ toes
☐ forehead ☐ chest ☐ buttocks ☐ lower arms ☐ abdomen
☐ sideburns ☐ shoulders ☐ thighs ☐ upper arms ☐ cheeks
☐ upper-lip ☐ chest/breasts ☐ calves ☐ hands ☐ fingers
☐ chin ☐ back ☐ feet ☐ pubic area

2. Which method are you removing the hair you are interested in laser removal?
☐ tweezing ☐ waxing ☐ shaving ☐ depilatory ☐ other

3. When was the last time you removed the unwanted hair by this method in that area?_____
How often? ☐ everyday ☐ once a week ☐ every other week ☐ once a month

5. Please check the one statement that best describes your skin at first sun exposure?
☐ always burned, never tan ☐ sometimes burn, tan about average
☐ usually burn, tan with difficulty ☐ rarely burn, tan with ease
☐ burn first and then tan ☐ never burn

6. When was your last sun exposure? circle (Indoor or Outdoor) ☐ one day ago ☐ one week ago ☐ one month ago

7. What level of sunscreen do you use on a regular basis on the area you wish to be treated?
☐ none ☐ SPF 15 ☐ SPF 30 ☐ SPF 45 ☐ higher

8. Are you currently tanned in the area(s) you wish to have treated? ☐ Yes ☐ No

9. Have you ever had cold sores in the area(s) to be treated? ☐ Yes ☐ No

10. Have you been on Accutane in the past six months? ☐ Yes ☐ No

11. Do you take medications routinely? ☐ Yes ☐ No
If yes, please list all medications.
_____

12. What is your ethnic background (eg German, French, Irish)_____

Patient Signature:_____
Date:_____