Laser Hair Removal Questionnaire

Patient name:_____ Date_____

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	[ ]calves	[ ]hands	[ ]fingers	[ ]chest/breasts
[ ]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:_____

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