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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