

IDEAL IMAGE®

LASER HAIR REMOVAL



Please Introduce Yourself...

Chart# _____

Name: _____ Today's Date: _____
(First Name) (Middle Initial) (Last Name)

Birth Date: ____ / ____ / ____ Age: ____ Male Female E-mail: _____
(Month) (Day) (Year)

Home Phone: () _____ Cell Phone: () _____

Home Address: _____

City: _____ State: _____ Zip: _____

Occupation: _____ Business Phone: () _____

Married? Yes No Spouse's Name: _____

In case of emergency, please contact:

Name: _____

Phone: () _____ Cell Phone: () _____

May we share your medical information with this person? Yes No

Where did you hear about Ideal Image®?

Friend or Family Member, Name: _____

Physician Referred, Name: _____

Radio TV Billboard Magazine/Newspaper Internet Local Event Other _____

How do you preferred to be contacted? Phone E-mail

Would you like to receive special offers and promotions from Ideal Image® via e-mail? Yes No

What are your three favorite radio stations? _____

What are your three favorite web sites? _____

We do not sell any customer information to any third party. Neither do we provide any individually identifiable customer information to any third party except as follows: in response to subpoenas, court orders or legal process, in order to finalize a payment for services requested and agreed to with your personal Ideal Image® consultant. This information may be shared with your financial institution or credit card issuer as indicated.

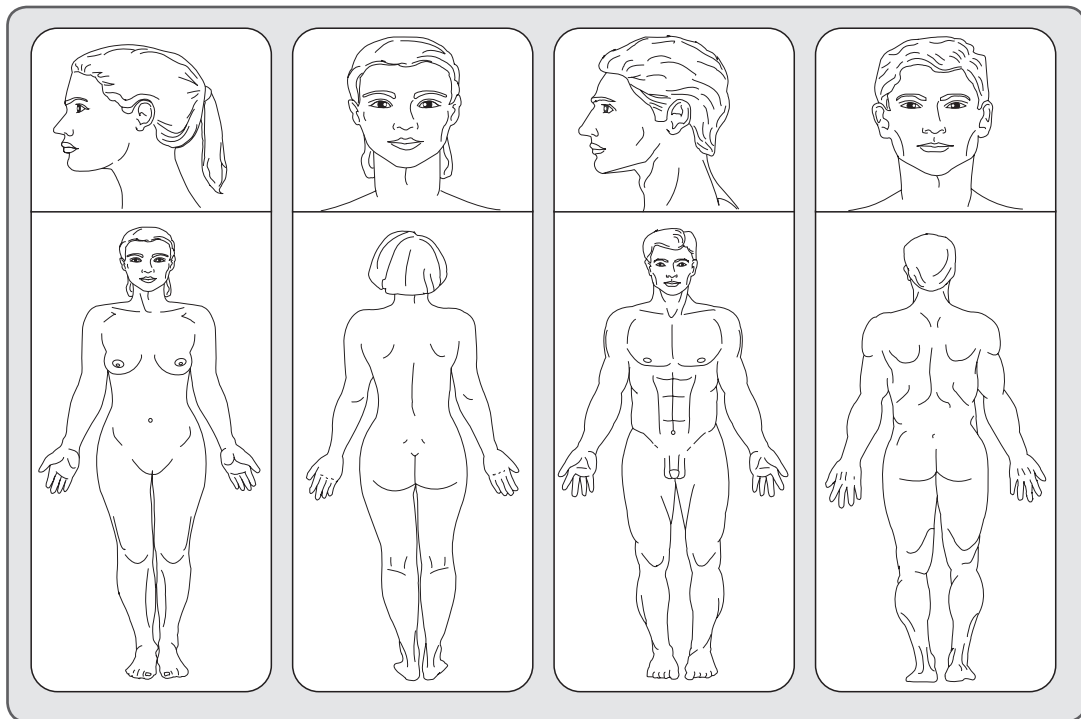
Name _____ Chart# _____

Please Tell Us About Yourself...

Have you ever had laser treatments or cosmetic procedures? Yes No

Procedures/Areas treated: _____ Any complications? _____

Please Circle The Areas You Need Treated On The Diagram Below



In order to better establish your skin type, please tell us your race/ethnicity: _____

Please Check The Box That Best Describes Your Skin Type:

- Skin Type I Never tans, always burns (extremely fair skin, blonde hair, blue/green eyes)
- Skin Type II Occasionally tans, usually burns (fair skin, sandy/brown hair, green/brown eyes)
- Skin Type III Often tans, sometimes burns (medium skin, brown hair, brown eyes)
- Skin Type IV Always tans, never burns (olive skin, brown/black hair, dark brown/black eyes)
- Skin Type V Never burns (dark brown skin, black hair, black eyes)
- Skin Type VI Never burns (black skin, black hair, black eyes)

Is your skin sensitive? Yes No

Name _____ Chart# _____

Medical History

How would you describe your general health? Good Fair Poor

Have you had a major illness or been hospitalized within the last 5 years? Yes No

Please describe: _____

Are you currently using any medications? (Topical, Ingestible or Injectable) Yes No

List all medications and conditions: _____

Do you have acne? Yes No

Are you taking Accutane? Yes No

Have you taken Accutane in the last 6 months? Yes No

Are you using Rogaine, Propecia, Minoxidil? Yes No If yes, please list: _____

Are you using steroids? Yes No

Have you ever had gold injections? Yes No

Are you allergic to Latex? Yes No

Do you have any tattoos? Yes No If yes, where? _____

Are you allergic to any medications? Yes No Please list: _____

Are you taking Aspirin, Advil, Motrin or any other over the counter medications? Yes No

List: _____

Are you taking any herbal or vitamin supplements? Yes No List: _____

Do you use tobacco? Yes No Type: _____

Do you consume more than two alcoholic beverages per day? Yes No

Have you ever had any of the following:

Skin Cancer or Pre-Cancer: Basal Cell Dysplastic Nevus Squamous Cell Melanoma

If yes, when: _____ Where on the body: _____

Was it treated and how? _____

Name _____ Chart# _____

Have you ever had any of the following:

- | | | | |
|---|--|--|---|
| <input type="checkbox"/> Hormone Disorders | <input type="checkbox"/> PCOS | <input type="checkbox"/> HIV or AIDS | <input type="checkbox"/> Venereal Disease (syphilis, gonorrhea, etc.) |
| <input type="checkbox"/> Hepatitis A | <input type="checkbox"/> Phlebitis | <input type="checkbox"/> Dermatitis | <input type="checkbox"/> Herpes (genital) |
| <input type="checkbox"/> Hepatitis B | <input type="checkbox"/> Anemia | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Cold Sores |
| <input type="checkbox"/> Hepatitis C | <input type="checkbox"/> Nervous Disorder | <input type="checkbox"/> Sinus or Ear Trouble | <input type="checkbox"/> Angina (chest pains, pacemaker, heart valve, etc.) |
| <input type="checkbox"/> Heart Disease or Condition | <input type="checkbox"/> Lupus | <input type="checkbox"/> Ulcers | <input type="checkbox"/> Artificial Transplants or Implants |
| <input type="checkbox"/> Eye Diseases | <input type="checkbox"/> Eczema | <input type="checkbox"/> Methemoglobinemia | <input type="checkbox"/> Abnormal Blood Pressure (high or low?) |
| <input type="checkbox"/> Epilepsy/Seizures | <input type="checkbox"/> Jaundice, Liver Disease | <input type="checkbox"/> Respiratory Condition | <input type="checkbox"/> Keloid Scarring |
| <input type="checkbox"/> Excessive Bleeding | When: _____ | | Describe: _____ |

Psychiatric Care Please explain: _____

Have you ever had any surgical procedures? Yes No

Please describe: _____

Have you ever had any of the following treatments: Chemical Peel Laser Peel BOTOX®

Glycolic Peel Microdermabrasion Cosmetic Surgery Other: _____

What skin care products are you using? (Cleanser, Moisturizer, etc.) _____

Do you use or have you ever used any of the following products? Retin A AHA Hydroquinone

Other: _____ Any reactions? _____

Is there any other information about your health that we should know? _____

WOMEN ONLY: Are you pregnant? Yes No Expected Delivery Date: _____ / _____ / _____

Are you trying to become pregnant? Yes No Are you currently nursing? Yes No

Are you taking oral contraceptives? Yes No

Patient Signature: _____ **Date:** _____ / _____ / _____

Person responsible for account (If under 18)

Parent/Legal Guardian Signature: _____ **Date:** _____ / _____ / _____

OFFICE USE ONLY:

Confirmed by: _____ **Date:** _____ / _____ / _____

Treatment Provider Signature