

# Dr. Michele Zormeier

## LASER HAIR REMOVAL ASSESSMENT

Patient Name \_\_\_\_\_ Date \_\_\_\_\_

What areas do you wish to have treated?

\_\_\_\_\_  
\_\_\_\_\_

Are you currently under the care of a physician?  yes  no  
Are you or is it possible you may be pregnant?  yes  no  
Do you use Glycolic Products or Retin-A?  yes  no  
Are you on antibiotics or Accutane therapy?  yes  no

Please list any medications you are taking:

\_\_\_\_\_  
\_\_\_\_\_

Do you have any unusual scars? (raised, darkened, etc.)  yes  no

Have you ever had:

A sensitivity to an anesthetic (Lidocain/EMLA)  yes  no  
A photosensitive disorder (lupus, sun rash)  yes  no  
A history of skin cancer or atypical moles  yes  no

Do you currently have or have you ever had:

Keloidal scarring  yes  no  
HIV/AIDS  yes  no  
Cold sores  yes  no  
Hepatitis  yes  no  
Herpes  yes  no  
Recent increase in the amount of hair  yes  no  
Diabetes  yes  no  
Previous laser, electrolysis or waxing  yes  no

When \_\_\_\_\_

Recent exposure to sun, a tanning bed or self-tanning products  yes  no

When \_\_\_\_\_

Do you have a tan now?  yes  no  
 yes  no

Select the one description that would describe you if you were exposed to strong sun with NO sun block:

- I always burn and never tan  
 I always burn and sometimes tan  
 I sometimes burn and sometimes tan  
 I always tan and rarely burn  
 I have moderately pigmented skin (Asian, Hispanic, African American, or Mediterranean descent)