

Caddell's Laser and Electrolysis Clinic
Confidential Medical History

Last Name: _____ First Name: _____ MI: _____

Address: _____

City: _____ State: _____ Zip: _____ DOB: _____

Home Phone: _____ Can we leave a message at home? Yes / No

Work Phone: _____ Can we leave a message at work? Yes / No

Email: _____ Can we put you on our mailing list? Yes / No

How did you hear about us? _____

MEDICAL HISTORY

CIRCLE ANY MEDICATIONS OR PROBLEMS YOU HAVE FROM THE LIST BELOW:

Antibiotics	Blood Thinners	Diuretics	Keloid Scars	Blood Clots
Accutane	Canker Sores	Eczema	Leukemia	Vascular Disease
Acne	Cold Sores	Latex Allergies	Metal Pins	HIV
Aspirin	Contacts	Heart Conditions	Moles	Multiple Sclerosis
Birth Control	Diabetes	Hepatitis	Vitiligo	Immunosuppression
Psoriasis	Skin Infection	Skin Cancer	Pacemaker	Cancer
Anemia	Rheumatoid Arthritis	High Blood Pressure	Bleeding Disorders	
Blood Disease	Collagen Vascular Disease	Hormones	Acute or Chronic Kidney Disease	

List any Present Illness: _____

List any Chronic Disease: _____

List any Past Surgical History: _____

Have you experienced post inflammatory hyper pigmentation (brown pigmentation in the skin)? Yes / No

Please list your Present Medications (please include any herbal medication(s)): _____

Please list any allergies (to medications or materials): _____

Female Client Medication Information:

Are you pregnant? Yes / No Do you have polycystic ovarian syndrome? Yes / No

Are you breastfeeding? Yes / No Do you have any endocrine problems at present? Yes / No

Are you in menopause? Yes / No Are you on birth control or hormone medication? Yes / No

Regular periods? Yes / No Have you ever had Gold Therapy? Yes / No

Other: _____

I acknowledge the above medical history is thorough, correct and accurate to the best of my knowledge.

Signature: _____ Date: _____

Printed Name: _____

**Caddell's Laser and Electrolysis Clinic
Confidential Medical History**

Treatment Desired _____

Desired Treatment Area(s): (Please circle)

Abdomen	Full Legs	Hairline	Nose
Under Arms	Ears	Lip: Upper / Lower	Private Areas
Forearms	Eyebrows	Breasts	Neck
Upper Legs/Thigh	Back	Chin	Hands / Fingers
Lower Legs	Chest	Feet/Toes	Bikini
Other: _____			

CURRENT EVALUATION OF SKIN / HAIR

Previous Treatments:

Electrology	Yes / No
Laser	Yes / No
Electric Tweezers	Yes / No
None	

Temporary Methods:

Shaving	Yes / No
Tweezing	Yes / No
Depilatories	Yes / No
Waxing	Yes / No

SKIN TYPE

How Do You Tan? (Check one)

Very Good
 Fairly Good
 Not Good
 Burn Easily

How Do You Heal?

Very Good
 Fairly Good
 Slow Healer

Office Use Only

Fitzpatrick Skin Type

Initial: _____

Last Exposure to Sun or Tanning Bed: Date: _____

Last Use of Self-Tanning Product: Date: _____

Do you have any interest in our other services? (Check all that apply)

Spider Vein Treatment <input type="checkbox"/>	Laser Tattoo Removal <input type="checkbox"/>	Facial Vein Treatments <input type="checkbox"/>
Microdermabrasion <input type="checkbox"/>	Chemical Peels <input type="checkbox"/>	Facials <input type="checkbox"/>
Electrolysis <input type="checkbox"/>	LED Light Treatments <input type="checkbox"/>	Leg Vein Treatment <input type="checkbox"/>
Broken Capillaries <input type="checkbox"/>	Brown or Red Spots <input type="checkbox"/>	Skin Tag Removal <input type="checkbox"/>
Facial Enhancements: <input type="checkbox"/>	Botox for Wrinkles and Fine Lines	
<input type="checkbox"/>	Lip Augmentation (plumping and definition) with Injectable Fillers (Juvederm, Restylane)	
<input type="checkbox"/>	Treatments for wrinkles, folds and lines around the eyes, nose and mouth	

I am aware that my initial medical evaluation is performed by a Staff Physician Assistant (PA) who will review my medical history and initiate or review treatment. Treatments may then be delegated to and performed by Staff Nurses and Estheticians. This is in compliance with the State of Washington laws regarding the use of laser for hair removal.

Signature: _____ Date: _____

Printed Name: _____