ELIMINATION STATION
Laser Tattoo Fading & Removal

CLIENT INFORMATION & MEDICAL HISTORY

Please complete the following questionnaire prior to treatment. All information is strictly confidential.

PERSONAL HISTORY

Client Name _____ Today's Date _____
Date of Birth_____ Age_____Occupation _____
Home Address_____ City_____ State_____ Zip _____
Home Phone (_____) _____-_____ Cell Phone (_____) _____-_____
Email_____
Emergency Contact Name and Phone _____
How did you hear about us? Please circle one
INTERNET SEARCH (Google / Yahoo / MSN): Search Term Used: _____
OTHER: _____ REFERRED BY: _____

Which of the following best describes your skin type? (Please circle one type number)

I	Caucasian, fair skin, light eyes	IV	Mediterranean, Asian, Hispanic
II	Caucasian, fair to tan skin, medium eyes	V	Middle Eastern, Latin, Light-skinned African, Indian
III	Darker Caucasian, light Asian, Tan complexion	VI	Dark-skinned African

How old is your tattoo for removal?_____ Is it homemade or professional? _____
Short description of your tattoo(s): _____

MEDICAL HISTORY

Are you currently under the care of a physician? ❑Yes ❑No If yes, for what: _____
Are you currently under the care of a dermatologist? ❑Yes ❑No If yes, for what:_____
Have you ever had a reaction to a previous laser treatment, heat treatment, or radiation therapy? ❑Yes ❑No
Do you have any of the following medical conditions? (Please check all that apply)
❑Cancer ❑Diabetes ❑Herpes ❑Arthritis ❑Frequent cold sores ❑HIV/AIDS ❑Keloid scarring ❑Skin disease/Skin lesions ❑Seizure disorder
❑Hepatitis ❑Blood clotting abnormalities ❑Any active infection
Do you have any other health problems or medical conditions? Please list: _____

MEDICATIONS

What oral medications are you presently taking? Please List: _____
Have you ever taken Accutane for acne? ❑Yes ❑No If yes, when did you last use it? _____
What topical medications or creams are you currently using? ❑ Retin-A® ❑Others (Please list): :_____
Have you ever had an allergic reaction to any medication? Please List: _____

HISTORY

Do you currently have a sunburn? ❑Yes ❑No
Do you form thick or raised scars from cuts or burns? ❑Yes ❑No
Do you have Hyperpigmentation (darkening of the skin) or Hypopigmentation (lightening of the skin) or marks after physical trauma? ❑Yes ❑No
If yes, please describe: _____ For our female clients: Are you pregnant or trying to become pregnant? ❑Yes ❑No Are you breastfeeding? ❑Yes ❑No

I certify that the preceding medical, personal and skin history statements are true and correct. I am aware that it is my responsibility to inform the technician, doctor, or nurse of my current medical or health conditions and to update this history. A current medical history is essential for the caregiver to execute appropriate treatment procedures.

Signature_____ Date:_____