Lotus Spa Eau Claire

Laser Intake Form

Full Name_____

Date of Birth_____Occupation_____

Email _____

Mobile Phone _____ Home Phone_____Work Phone_____

Emergency Contact Name_____Phone Number_____

Appointment and Event notification consent- Circle all that apply

Telephone Email Text Message

_____

Medical Conditions- Check all that apply

- ☐ History of cold sores
- ☐ Use of Blood Thinners, Aspirin or NSAIDS
- ☐ Epilepsy or seizures
- ☐ Accutane use in the past 6 months
- ☐ Connective tissue disorder or autoimmune disease
- ☐ Use of Retin-A, Retinol, Hydroquinone, or topical steroids
- ☐ Abnormal scarring or keloids

Medications- Please list all medications, vitamins, and supplements you are taking

_____

_____

_____

_____

Please list any medication allergies

_____

Are you pregnant or breastfeeding? ☐ Yes ☐ No

Please list any surgeries you have had

_____

What skin care, injection, or laser treatments have you had?

_____

I have answered all questions truthfully and disclosed my medical history to the best of my knowledge.

Patient Signature_____**Date**_____

Witness Signature_____**Date**_____