SOUTHERN LASER SALON
PATIENT CONSULTATION FORM
FOR LASER HAIR REMOVAL

Date: _________________

Name: __________________ Age: ________________ DOB: _________________________________

Chief Complaint: ____

Past Medical History: ____

Surgical History: ____

Medications: ____

Allergies: ____

History:	**Yes**	**No**	**Date of last exposure**
Waxing	X	X	_____________________
Plucking	X	X	_____________________
Electrolysis	X	X	_____________________
Shaving	X	X	_____________________
Acutance	X	X	_____________________
Cold sores/herpes	X	X	_____________________
Previous laser tx	X	X	_____________________
Keloids	X	X	_____________________
Perm lip/collagen	X	X	_____________________
Deodorant	X	X	_____________________

Circle One:

- Benefits of procedure discussed: **Yes No**
- Contraindications reviewed: **Yes No**
- Probability of success reviewed: **Yes No**
- Patient educated about anticipated consequences if treatment (tx) is not performed; and alternative procedures available: **Yes No**
- Verbal and written post-treatment instructions given to patient: **Yes No**
- Famvir Rx given: **Yes No**
- Next appointment scheduled: **Yes No** Date: ____/____/____
- Risks reviewed (pigment changes, bruising, swelling, infection, scarring, reoccurrence of hair, blistering): **Yes No**

Comments:

Signature of consultant: ____

Date: ___/___/___