



MEDICAL SPA

PRE – TREATMENT QUESTIONNAIRE

PATIENT NAME: _____

LASER TREATMENT: _____ BODY AREA TO BE TREATED: _____

HAVE YOU BEEN TANNING OR HAD ANY SIGNIFICANT SUN EXPOSURE IN THE LAST 7 DAYS?	Y	N
ARE YOU WEARING ANY LOTIONS, OILS, COSMETICS OR DEODORANTS? [IN AREA BEING TREATED]	Y	N
ARE YOU ON ANY MEDICATIONS WHICH MAY CAUSE SUN SENSITIVITIES? IF YES, PLEASE LIST: _____	Y	N
HAVE YOU STARTED ANY NEW MEDICATIONS / SUPPLEMENTS SINCE YOUR LAST VISIT? IF YES, PLEASE LIST: _____	Y	N
HAVE YOU USED ANY RETIN-A PRODUCTS IN THE LAST 7 DAYS?	Y	N
HAVE YOU TAKEN ACCUTANE WITHIN THE LAST 6 MONTHS?	Y	N
ARE YOU PRONE TO COLD SORES? IF YES, ARE YOU TAKING AN ANTI-VIRAL MEDICATION? _____	Y	N
HAVE YOU TWEEZED OR WAXED YOUR HAIR IN THE LAST 6 WEEKS? [ONLY FOR LASER HAIR REMOVAL]	Y	N
ARE YOU USING ANY PRODUCTS CONTAINING GLYCOLIC, SALICYLIC, LACTIC, OR ANY ALPHA HYDROXY ACIDS?	Y	N
HAVE YOU TAKEN ANY ASPIRIN WITHIN THE LAST 10 DAYS?	Y	N

I HAVE ANSWERED THESE QUESTIONS TRUTHFULLY & I AM AWARE IT IS MY RESPONSIBILITY TO INFORM THE DOCTOR / LASER TECH / NURSE OF MY CURRENT MEDICAL OR HEALTH CONDITIONS & TO UPDATE MY HISTORY.

PATIENT SIGNATURE: _____ DATE: _____