SALMON CREEK PLASTIC SURGERY

LASER SERVICES

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

DO YOU HAVE PERMANENT COSMETICS OR TATTOOS ? 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 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 OR PRESCRIPTION TRETINOIN? 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:** ____/_____/_____

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