**GentleLase and Varia Laser Hair Removal Questionnaire Form**

Name: ________________________________________ Date: ______________________________

What areas are you interested in treating? __________________________________________________

Type of hair: Coarse  Fine  Dark  Light

Drugs or medicines to which you are allergic: _______________________________________________

Names of all medicines you are now taking including Over the Counter products: __________________

_________________________________________________________________________________

_________________________________________________________________________________

Have you recently taken Accutane? ______________________________________________________

Do you have a history of keloids/hypertrophic scars? _________________________________________

Have you had any previous laser treatments? _______________________________________________

When? __________How many? ____________ How frequently? ___________ Response? __________

Do you have any other illness or medical condition? ___________________________________________

What is your current method of hair removal? Wax___Shaving______ Tweezing_____ Electrolysis____

When did you last use this method? _______________________________________________________

How would you best describe your goal for this treatment?

___Complete removal of all hair
___Removal of 75% of the hair
___Removal of 50% of the hair
___Anything would be an improvement

Skin Type: ______________________________ Endocrine Function: ____________________________

Discussion of how laser works
__Type of laser
__History of laser
__FDA clearance

Discussion of Pre-procedure preparation
__Limit Sun Exposure
__Termination of other treatment
__Shave area one week before treatment
__Use and application of topical anesthetic

Discussion of Risks
__Scarring
__Hypo pigmentation

Discussion of Treatment
__How treatment feels
__How long treatment takes

__Hyper pigmentation
__Possible stimulation of hair growth
__Incomplete hair removal

__Provider of treatment

Discussion of aftercare
__Number of treatments expected
__What to expect after treatment
__How to treat: pain and swelling
__Average number of treatments for area
__Waiting period between treatments

Discussion of alternative treatments
__Electrology
__Bleach
__Wax, shave etc.

Esthetician Notes: ____________________________________________________________________

________________________________________________________________________________

________________________________________________________________________________

________________________________________________________________________________

**Areas to be Treated**

*Area to be treated: ________________________________________________________________

Cost per treatment: #1_______ #2_______#3________#4________#5________#6________#7________

*Area to be treated: ________________________________________________________________

Cost per treatment: #1_______ #2_______#3________#4________#5________#6________#7________

*Area to be treated: ________________________________________________________________

Cost per treatment: #1_______ #2_______#3________#4________#5________#6________#7________

Please note: In the event that a patient requests additional areas to be treated, the cost of treatment will result in additional charges.

**This treatment quote is valid for treatments started by ___________ and completed by ___________. Prices are subject to change without prior notice.

**Payment:**
Cosmetic procedures are payable in full at the time treatment is rendered. We accept cash, personal checks, money orders, cashier's checks, Visa, MasterCard, Discover and American Express for payment.

**Appointment Policy:**
Patient must provider 24 hours advance notice in the event of cancellation of a scheduled appointment.

_____________________________________ ____________________________________________

Authorized Signature/Date Patient Signature or Receipt/Date

(Patient signature if verification that the information provided on this form is accurate.  This is not a consent or obligation for treatment.)

Please note that APDerm® will honor the cost for treatment as stated above for a period of (30) days from the date of this consultation.