

Avante Laser & MediSpa Confidential Client History

Name _____ Date _____

Address _____ City/State _____ Zip _____

Home Phone(____) _____ Work Phone(____) _____ Occupation _____

Marital Status _____ Date of Birth _____ Email Address _____

Referred By _____ (i.e. Person, Yellow Pages, Newspaper, Physician, or other)

May we call to confirm your appointments? Yes No Tel.# (____) _____

Desired Treatment Areas (Please Circle)

Abdomen	Chest	Feet/Toes	Neck: Front/Back
Arms: Fore/Under	Chin	Hairline	Nose
Back	Ears	Hands/Fingers	Private Areas
Bikini: Line/Full	Eyebrows	Lip: Upper/Lower	Thighs
Breast	Face: Sides/Full	Legs	Other _____

At what age was onset of hair growth? _____ Was onset sudden or gradual? _____

Family members with similar growth patterns _____

Do you have a dark centerline of heavy hair growth on the abdomen or between the breasts? No Yes

What temporary procedures have you been using to rid the hair? (please circle) Tweezing Shaving Waxing

How often do you have to perform this procedure? (daily, weekly, etc.) _____

Have you had previous electrolysis or laser treatments? No Yes When? _____ Area? _____

Did you experience any adverse skin reactions to your treatment? No Yes Explain _____

Medical (Please Circle N for No and Y for Yes)

Acne	N Y	Gold Therapy	N Y	IUD	N Y	Obesity	N Y
Anaphylaxis	N Y	HIV	N Y	Implants	N Y	Ovarian Disorder	N Y
Canker/Cold Sores	N Y	Hearing Aid	N Y	Keloid Scars	N Y	Pacemaker	N Y
Carcinoma	N Y	Heart Condition	N Y	Metal Pins	N Y	Pigmentation	N Y
Contact Lenses	N Y	Hemophilia	N Y	Migraines	N Y	Telangiectasia	N Y
Dermatitis/Eczema	N Y	Hepatitis	N Y	Mitral Valve	N Y	Thyroid Disorder	N Y
Diabetes	N Y	High Blood Pressure	N Y	Prolapse	N Y	Tuberculosis	N Y
Genital Herpes	N Y	Histamine Reactions	N Y	Moles	N Y	Vitiligo	N Y

Are you allergic to any of the following? (Please Circle) Rubbing Alcohol Witch Hazel Latex Gloves Aloe Vera Metals

Other _____ Please explain any above _____

Please list any medications that you are currently taking and any that you have taken in the past 12 months. (Including skin medications). _____

I will notify Avante of any changes in medication or of any new medications that I am taking.

(Sign and date) _____

For Females Only

In Menopause	N Y	Hormonal Imbalance	N Y	Endocrine Problem	N Y
Post Menopause	N Y	Pregnant	N Y	Hysterectomy	N Y
Regular Periods	N Y	Birth Control Pills	N Y	Other	N Y

Turn over and sign after reading to authorize laser treatment.