Laser Hair Removal Contraindications

Patient Name ______________________________ **Date** _______________________________

Allergies ____

Please list all current medications including oral, topical, over the counter, and herbal

supplements ____

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History or HSV (cold sores, fever blisters)	Yes	No
Sun exposure in the past 2 – 4 weeks (including self-tanning products)	Yes	No
Waxing, tweezing, plucking, depilatories, or electrolysis in the area to be treated in the past 4-6 weeks	Yes	No
Use of Retin-A, glycolic acid, bleaching cream, or prescription topical in the last 3-4 days	Yes	No
Current use of antibiotics	Yes	No
Are you pregnant?	Yes	No
Cosmetic tattoos / permanent make-up in the area to be treated	Yes	No

Signature _________________________________ Date ___________________________

Signature _________________________________ Date ___________________________

Signature _________________________________ Date ___________________________

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