CLIENT HISTORY AND TREATMENT PLAN FOR PIGMENT (TATTOO) LIGHTENING/REMOVAL

Name	Date	Gender - Female ☐ Male ☐	Birth Date
Address	City	State	Zip
Employer	Ph-H	Ph-W	Ph-Cell
Occupation	E-Mail	Physician's Name	Physician's Ph. No.

1	YES	NO	Are you under a physician's care for any medical condition at this time?	27	YES	NO	Have you ever had cold sores?
2	YES	NO	Are you pregnant or nursing?	28	YES	NO	Do you have any type of herpes?
3	YES	NO	Do you have eczema?	29	YES	NO	Do you wear contact lenses?
4	YES	NO	Do you have psoriasis	30	YES	NO	Do you wear glasses?
5	YES	NO	Do you have hemophilia?	31	YES	NO	Do you have glaucoma?
6	YES	NO	Do you have acne?	32	YES	NO	Do you have dry eye syndrome?
7	YES	NO	Do you have skin cancer?	33	YES	NO	Do you have blocked tear ducts?
8	YES	NO	Do you have vitiligo?	34	YES	NO	Do you have allergies to latex?
9	YES	NO	Do you have rosacea?	35	YES	NO	Do you bruise easily?
10	YES	NO	Do you have dermatitis?	36	YES	NO	Do you have any problems healing from minor wounds?
11	YES	NO	Do you hyperpigment when you scar?	37	YES	NO	Do you tend to develop keloid or hypertrophy scars?
12	YES	NO	Do you hypopigment when you scar?	38	YES	NO	Do you have a tendency to faint or become dizzy?
13	YES	NO	Have you had plastic surgery?	39	YES	NO	Are you undergoing radiation or chemo-therapy treatment?
14	YES	NO	Are you contemplating plastic surgery?	40	YES	NO	Are you sensitive to petroleum based products?
15	YES	NO	Do you have high blood pressure?	41	YES	NO	Are you now, or have you ever been on the acne treatment accutane?
16	YES	NO	Do you have low blood pressure?	42	YES	NO	Are you under treatment for depression?
17	YES	NO	Do you have asthma?	43	YES	NO	Do you take prescription drugs?
18	YES	NO	Do you have any type of heart disease?	44	YES	NO	Do you intentionally tan- direct sun or tanning bed?
19	YES	NO	Do you wear a pace maker?	45	YES	NO	If you tan, do you burn easily?
20	YES	NO	Do you have any medical implants?	46	YES	NO	Do you have a history of stroke or heart attack?
21	YES	NO	Do you have diabetes or any autoimmune disorders?	47	YES	NO	Do you take any herbal supplements?
22	YES	NO	Do you have any seizure related condition?	48	YES	NO	Do you have any problems being anesthetized for dental procedures?

If you answered "**Yes**" to any questions above, use the space below to provide an explanation. Correlate your explanations to a specific question / number. *(Example: 1. Yes I am nursing, 15. High Blood Pressure, 42. My list of prescription drugs etc.)*

Client Signature:_____ Date: _____