

NAME: _____ TEL: _____ CELL: _____ EMAIL: _____

ADDRESS: _____ CITY: _____ POSTAL CODE: _____

Please help to assist your treatment by filling in the health related questions. Please ensure to check off any of the conditions that you occasionally or frequently have or experienced.

CONDITION	✓	CONDITION	✓	CONDITION	✓
Contact Lenses		Melasma		Hepatitis	
Bridges/Fillings/Braces		Dermatitis		Skin Cancer	
Allergies		Rashes/Hives		Cancer/Tumour	
Anaphylactic Shock		Eczema		Diabetes	
Asthma/Sinus		Psoriasis		Edema	
Acne Problems		Cold Sores		Arthritis	
Rosacea		Genital Herpes		Heart Disease	
Sensitive Skin		Varicose Veins		Postpartum Depression	
Skin Issues		Bruises Easy		Breast Feeding	
Recent UVR Exposure		Pacemaker		Pregnant	
Recent Tanning Bed Exposure		High/Low Blood Pressure		Hysterectomy	
Recent Self Tanners		Phlebitis		Hormone Replacement Therapy	
Heat Sensitivity		Stress/Anxiety		Kidney Disease	
Sun Sensitivity		Lupus		Thyroid Problems	
Hyperpigmentation		HIV+/Aids		Adrenal Fatigue	
Hypopigmentation		Tuberculosis		Epilepsy	
Vitiligo		Keloid Scars		Fibromyalgia	

Others not listed: _____

Please list if you have currently or recently (last 6 months) taken any of the following medications:

Please check any of the following medical treatments you have previously undergone:

Prescriptions:
Retinoids/AHA/Vitamin A:
Accutane:
Antibiotics:

Chemical Peels		Microdermabrasion	
Laser Hair Removal		Laser Vein Removal	
IPL/Photo-Rejuvenation		Electrolysis	
Sclerotherapy		Botox/Fillers	

I am aware that it is my responsibility to disclose any and all medical conditions, medications and health related concerns prior to receiving treatment in order to prevent any possible health related or other risks to myself. In Consideration, Lēzara Laser & Vein Care, agreeing to provide me with treatments specified above, I agree not to hold liable Lēzara Laser & Vein Care their employees or contractors for any damage, including with limitation, personal or bodily injury of any kind, allergies, reactions or illness that I may sustain as a result of any of the medi-aesthetic treatments carried out.

CLIENT SIGNATURE: _____ DATE: _____

DOCTOR/TECHNICIAN SIGNATURE: _____ DATE: _____