

# Laser Hair Removal Consultation Form

**Male Skin Clinic**  
skin care & laser for men

**Pages 1 & 2 to be  
completed prior your  
patch test session**

## Client Information

Click in the blue boxes below and fill in your details accurately.

|           |               |
|-----------|---------------|
| Name      | Date of Birth |
| Address   | Age           |
| Town      | Gender        |
| Post Code | Phone         |
| Email     | Date          |

## Medical Information

Click in the blue boxes below and fill in your details accurately.

|            |          |
|------------|----------|
| GP Name    | GP Phone |
| GP Address |          |

### Do you have or suffer from any of the following:

|                           |     |    |                            |     |    |
|---------------------------|-----|----|----------------------------|-----|----|
| Allergies                 | Yes | No | High/Low Blood Pressure    | Yes | No |
| Heart Conditions          | Yes | No | Arthritis                  | Yes | No |
| Pacemaker                 | Yes | No | Skin Condition             | Yes | No |
| Muscular Condition        | Yes | No | Thrombosis                 | Yes | No |
| Viral/Bacterial Infection | Yes | No | Water Retention            | Yes | No |
| Auto Immune Condition     | Yes | No | Varicose Veins             | Yes | No |
| Kidney Disorder           | Yes | No | Burns / Skin Graft         | Yes | No |
| Asthma                    | Yes | No | Nerve Damage               | Yes | No |
| Hormonal Disorder         | Yes | No | Steroid                    | Yes | No |
| Metal Implants            | Yes | No | Cold Sores                 | Yes | No |
| Silicone Implants         | Yes | No | Allergic to Ultrasonic Gel | Yes | No |
| Hypoglycemia              | Yes | No | Botox within last 2 months | Yes | No |
| Pregnancy                 | Yes | No | Tattoos                    | Yes | No |
| Breast Feeding            | Yes | No | Fake Tan                   | Yes | No |
| Epilepsy                  | Yes | No | Taking any medication      | Yes | No |

**If you have answered yes to any of the above please  
give details or any other medical details:**

### Taken any of the following in the last 6 months:

|              |               |
|--------------|---------------|
| Retin-A      | Diuretics     |
| Antibiotics  | Contraceptive |
| Accutane     | HRT           |
| Tetracycline | Steroid Cream |

# Laser Hair Removal Consultation Form

Circle or make notes for the treatment area

## Treatment Information

Fill in the boxes below about where the treatment is required

Face Treatment Area

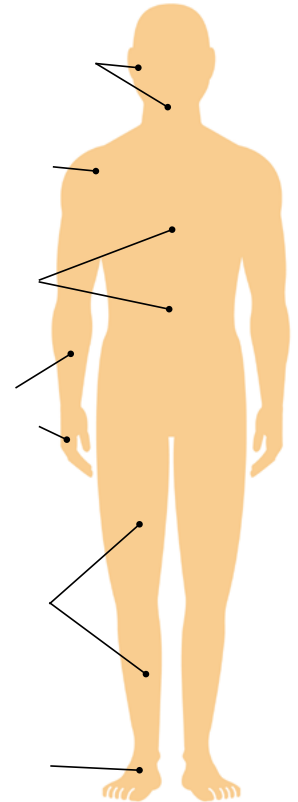
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Body Treatment Area

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Treatment Notes

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### Before Your Treatment

Avoid hair removal creams for 2 weeks before or during the treatment course

Avoid products containing retinol or having a peel on treatment area

No waxing, plucking or threading the treatment area. Shaving only.

Do not sunbathe or use sunbeds 4 weeks prior to and after treatment

Do exfoliation treatment area to help reduce ingrowing hairs

### After Your Treatment

No deodorant or perfumed products on treated area

No waxing, plucking or threading the treatment area during the course

No hot showers, steam, sauna, swimming or heavy exercise for 48 hours

An SPF 30+ must be worn on exposed skin daily to avoid sun damage

Redness of the skin, apply aloe vera gel for cooling the area following treatment

## Determining Your Skin Sensitivity

Calculate your skin sensitivity score

|   | Score 0                  | Score 1             | Score 2                 | Score 3               | Score 4               | Select Score |
|---|--------------------------|---------------------|-------------------------|-----------------------|-----------------------|--------------|
| What is the colour of your eyes                                       | pale blue, grey or green | blue, grey or green | pale brown              | dark brown            | brown/black           |              |
| What is the colour of your hair?                                      | ginger                   | blonde              | light brown             | dark brown            | black                 |              |
| What is the colour of your non-exposed skin?                          | reddish                  | very pale           | pale with an olive tint | pale brown            | dark brown            |              |
| Do you have freckles?   | all over                 | medium              | a few                   | minimal               | none                  |              |
| How does your skin react to overexposure of the sun?                  | painfull redness         | burn with peeling   | burn without peeling    | rarely burn           | never burn            |              |
| How does your skin tan?   | never tan                | slight tan          | reasonable tan          | easily tan            | quickly brown         |              |
| Do you notice a colour change directly (some hours) later sunbathing? | never                    | hardly              | sometimes               | often                 | always                |              |
| Is your face sensitive in the sun?                                    | very sensitive           | sensitive           | normal                  | very resistant        | never have a problem  |              |
| When was your last sun tan?   | + 3 months ago           | 2 – 3 months ago    | 1 – 2 months ago        | less than a month ago | less than 2 weeks ago |              |
| Do you expose the area to be treated?                                 | never                    | hardly              | sometimes               | often                 | always                |              |

| Skin Sensitivity Score | Skin Type  |
|------------------------|------------|
| 0-7                    | Type 1     |
| 8-16                   | Type 2     |
| 17-25                  | Type 3     |
| 26-30                  | Type 4     |
| Over 30                | Type 5 & 6 |

**Total Your Skin Sensitivity Score**

Click here for more information about the laser treatment

You laser consultant will review this form with you at your laser patch test session

# Laser Hair Removal Consultation Form

**This page to be completed  
following your patch test**

## Terms & Conditions

- 1) I have been advised and have fully discussed the treatment that I will be receiving. I accept that I will require a minimum of 6 treatments for this procedure to be effective. The treatments offer hair reduction and results are not always 100% reduction of unwanted hair due to unique hair growth cycles. Treatments may need to be increased due to my skin type and hair density.
- 2) I am fully satisfied that I have completed the consultation form with regard to any medical conditions or medicines that I am taking and I can confirm that I am suitable to proceed with the above mentioned treatment. I understand that any falsifications of information submitted to you could be detrimental to my health and success of my treatment, and the company will not be held liable if this is the case.
- 3) I am aware that protective eyewear must be worn during the laser treatment, until I am told to remove them.
- 4) I am aware that I should reduce exposure to sunlight, during or immediately after treatment, as my skin will be more sensitive to the sun and apply a factor SPF 30+ to the treated area otherwise patchy, pigmentation (hyper/hypo) may occur.
- 5) I have been informed that possible side effects include temporary erythema, sensations of heat and possible bruising or blistering and wish to continue with these treatments and do not hold the clinic responsible for any of these resulting effects.
- 6) I understand that should there be a change in my hormonal balance (e.g. caused by certain medical conditions and other factors) or other physiological changes, treatment success may vary.
- 7) I understand that if I do not follow the recommended treatment plan then more treatments will be required.
- 8) I have been fully advised and I completely understand the implications of the treatment that I will be receiving, and at no time have I been misled or badly informed by the above mentioned therapist or company.
- 9) A surcharge will be applied if the area to be treated has not been shaved on the morning of each treatment.
- 10) Photographs, drawing and notes maybe taken of the treatment area and securely stored to assess treatment progress.
- 11) I am fully aware of the costs involved as detailed on this form.

## Treatment Area One

|                            |
|----------------------------|
| Area                       |
| Cost Per Session           |
| Agreed Sessions            |
| Standard Price             |
| Package Discount           |
| Package Total              |
| Date &<br>Client Signature |

## Treatment Area Two

|                            |
|----------------------------|
| Area                       |
| Cost Per Session           |
| Agreed Sessions            |
| Standard Price             |
| Package Discount           |
| Package Total              |
| Date &<br>Client Signature |

## Treatment Area Three

|                            |
|----------------------------|
| Area                       |
| Cost Per Session           |
| Agreed Sessions            |
| Standard Price             |
| Package Discount           |
| Package Total              |
| Date &<br>Client Signature |

## Treatment Area Four

|                            |
|----------------------------|
| Area                       |
| Cost Per Session           |
| Agreed Sessions            |
| Standard Price             |
| Package Discount           |
| Package Total              |
| Date &<br>Client Signature |

**This page to be signed following  
your patch test session**

## Declaration of Consent for Laser Hair Removal Treatment

Signature

Print Name

Date

Client

Therapist

Save and email this form to [info@maleskinclinic.co.uk](mailto:info@maleskinclinic.co.uk) or click the send button