

# Bradley J. Abrams, D. O.

DERMATOLOGY AND DERMATOLOGIC SURGERY  
BOARD CERTIFIED



## IPL and Hair Removal Pre-treatment Questionnaire

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

1. Is there a possibility that you might be pregnant?  Yes  No  
If yes, how many weeks pregnant are you? \_\_\_\_\_
2. Are you taking any medications that may make you more sensitive to the sun?  Yes  No  
If yes, list name(s) and last time taken \_\_\_\_\_
3. Are you taking any anticoagulants or blood thinning medications?  Yes  No  
If yes, list name(s) and last time taken \_\_\_\_\_
4. How frequently do you consume alcohol?  Daily  Weekly  Monthly  Occasionally
5. Are you taking any herbal preparations such as St. John's Wort?  Yes  No  
If yes, list \_\_\_\_\_
6. Do you wear contact lenses?  Yes  No
7. Are you planning a holiday in the sun (e.g., cruise etc.) in the near future?  Yes  No  
If yes, list the type of trip and date you are leaving \_\_\_\_\_
8. What area(s) would you like to have treated? \_\_\_\_\_
9. What are you hoping to achieve through these treatments?  
Please list intended results \_\_\_\_\_
10. Have you ever had a chemical peel, skin resurfacing, microdermabrasion, or photorejuvenation before?  Yes  No  
If yes, list type and date \_\_\_\_\_
11. Do you have a history of keloid scarring?  Yes  No  
If yes, please list the procedure that resulted in the scarring and the date it occurred  
\_\_\_\_\_
12. Have you used a tanning bed or sunless tanning product within the last 6 weeks?  Yes  No

### For Hair Removal Patients

13. Have you waxed, plucked, or used depilatory cream on the area(s) to be treated within the last 6 weeks?  Yes  No
14. Have you ever had electrolysis? If yes, where? \_\_\_\_\_