

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? _____