Medical Information

Attending physician:

Medication:

❑ Natural products	❑ Hormones	❑ Antibiotics
❑ Cortisone	❑ Oral contraceptives	❑ Epilepsy
❑ Persistent bleeding	❑ Anticoagulants	❑ Scars
❑ Arterial disease	❑ Anti-inflammatories	❑ Nervous disorders
❑ Menopause	❑ Thyroid	❑ Hemophilia
❑ Pregnancy	❑ Hepatitis (A-B-C)	❑ Dental implants
❑ AIDS	❑ Diabetes	❑ Herpes
❑ I.U.D.	❑ Sensibility loss	❑ Vitiligo
❑ Blood circulation problems	❑ Cancer / remission	❑ Skin cancer
❑ Metallic inclusion	❑ «Piercing»	❑ Tattoo
❑ Infectious disease	❑ Asthma	❑ Pacemaker
❑ Saline implants	❑ Contact lenses	
Allergies:	❑ to cosmetic products	❑ to iodine
	❑ to latex	❑ others:

Do you undergo or have you ever undergone:

❑ Vitamin A (retinoic acid)	❑ Accutane	❑ Gold salts
❑ Chemical peeling	❑ Laser	❑ Microdermabrasion

Last exposition to sun, sunbed or use of self-tans?

Have you ever noticed a sudden growth of your hair? ❑ Yes ❑ No

When? Where?

Temporary Methods

❑ Razor	❑ Scissors	❑ Wax
❑ Bleach	❑ Abrasives	❑ Depilatories
❑ Others:	Frequency:	

Permanent Methods

❑ High Frequency ❑ Combined Currents (*blend*)

Approximate number of sessions: Interval:

Reduction Methods

❑ Laser ❑ IPL

Approximate number of sessions: Interval:

Hair Exam

Density: Color:

State: Texture:

Abnormalities & Affections:

Remarks:

Skin Exam

Texture: Abnormalities:

Secretion: Affections:

Moisture: Sensitivity:

Remarks:

I declare that I have answered to all of the above questions to the best of my ability and I release this establishment, its manager and its employees of all responsibility concerning any damage or incident that may result from the treatment.

Signature: Date:

APILUS MD

Client Index

Permanent Hair Removal

Personal Information

File No.:

Last Name:

First Name:

Sex:

Address:

Home Phone:

Cellular Phone:

Work Phone:

E-mail:

Date of Birth:

Reference:

Date:

Treatments

	Date	Area	Time	Technique	Parameters	Probe	Remarks	Initials
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For more information call: 1.800.463.5566