PATIENT **LASER HAIR REMOVAL** TREATMENT RECORD

AND THERAPEUTICS
Patient Name: Date:
Skin Type: I II IV V Topical Anesthetic:
Sun Exposure since last tx? NO YES Technician: Technician:
Have you been on Accutane? NO VES When finished:
Have you taken any Photosensitive drugs? NO YES
Have you been on Antibiotics recently? NO YES /\ \ \ \ \ \ \ \ \ \ \ \ \ \ \
Are you using any Retinols, Exfoliators, Glycloics? NO YES ()
Have you had a Chemical Peel in the last 4 weeks? NO YES
Complications since last tx? NO YES W
Photos Taken? NO YES)/\/
Post-op Form to PT?

TREATMENT #1

AREA TREATED	Wavelength or Program	_	Spot Size mm	Fluence J/cm2	Pulse Width ms	Rep Rate Hz	# of Pulses
REACTION:							

TREATMENT #2

AREA TREATED	Wavelength or Program	Spot Size mm	Fluence J/cm2	Pulse Width ms	Rep Rate Hz	# of Pulses
REACTION:						

TREATMENT #3

AREA TREATED	Wavelength or Program	_	Spot Size mm	Fluence J/cm2	Pulse Width ms	Rep Rate Hz	# of Pulses
REACTION:							

TREATMENT #4

AREA TREATED	Wavelength or Program	_	Spot Size mm	Fluence J/cm2	Pulse Width ms	Rep Rate Hz	# of Pulses
REACTION:							

TREATMENT #5

AREA TREATED	Wavelength or Program	_	Spot Size mm	Fluence J/cm2	Pulse Width ms	Rep Rate Hz	# of Pulses
REACTION:							

TREATMENT #6

AREA TREATED	Wavelength or Program	_	Spot Size mm	Fluence J/cm2	Pulse Width ms	Rep Rate Hz	# of Pulses
REACTION:							