

Patient No:

Name:

DoB: / /

Address:

Medical History	Drug History	Previous Treatment	Comment	Skin Type:	Laser Log
Date: Area: <input type="checkbox"/> Makeup/ Sun tan/ Fake tan? <input type="checkbox"/> Skin disorders and care? <input type="checkbox"/> Not pregnant? <input type="checkbox"/> Any change since previous treatment? <input type="checkbox"/> Photo		<input type="checkbox"/> Adverse reactions: None / _____ <input type="checkbox"/> Result: No change / Fair / Good / Excellent <input type="checkbox"/> Comments:	<input type="checkbox"/> Post-treatment response <input type="checkbox"/> Red / End point / blister <input type="checkbox"/> Cooling <input type="checkbox"/> Alvera <input type="checkbox"/> Post treatment advise Notes:		
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