

Laser Lounge Med Spa, LLC
Medical History Form

Today's Date: ___/___/___

Birth date: ___/___/___

Name: _____

Home Address: _____

No. & Street City State Zip

Work Address: _____

No. & Street City State Zip

Home Phone: (____) _____ Work Phone: (____) _____

E-mail Address _____

Employer: _____ Occupation: _____

Are you now or have you been under the care of a physician within the last two years? ___
If yes, please provide Physician's Name, address and phone
number. _____

Person to contact in an emergency: _____

Name, Address & Phone No. _____

List any drug, makeup, skin or food allergies (i.e., soaps or cleansing creams): _____

Do you have or have you had any of the following conditions (answer Yes or No):

_____ Abnormal Heart Condition

_____ Cold Sores

_____ Herpes Simplex

_____ Hemophilia

_____ High or Low Blood Pressure

_____ Prolonged Bleeding

_____ Circulatory Problems

_____ Epilepsy

_____ Diabetes

_____ Fainting Spells/Dizziness

_____ Cataracts

_____ Glaucoma

_____ Are you using any eye drops or other ocular medications?

_____ Do you get pigment or brown spots from an injury, insect bite or cut?

_____ Are you currently taking aspirin or ibuprofen?

_____ Have you recently undergone a skin peel?

_____ Have you consumed any alcoholic beverage(s) in the past 24 hours?

What products do you use for skin care?

_____ Dry Eye

_____ Corneal Abrasions

_____ Eye Surgery or Injury

_____ Blepharoplasty

_____ Visual Disturbances

_____ Cancer

_____ Tumors/Growths/Cysts

_____ Chemotherapy/Radiation

_____ Are you pregnant?

_____ Hepatitis

_____ HIV/AIDS

_____ Do you wear contact lenses?

_____ Do you use tobacco products

Do have a history of any autoimmune disease? _____

Do you have a history of HSV 1 or HSV 2? _____

Do you have any implants/injectables/permanent makeup? If so please
list: _____

Do you have any Tattoos? _____ If so where? _____

Additional Information:

Skin Type (when exposed to the sun without protection for about 1 hour)

- | | |
|--|----------|
| ___ Always burns, never tans | Type I |
| ___ Always burns, sometimes tans | Type II |
| ___ Sometimes burns, sometimes tans | Type III |
| ___ Always tans | Type IV |
| ___ Hispanic, Asian, Mediterranean, Middle Eastern | Type V |
| ___ Black | Type VI |

When were you last exposed to the sun, including tanning booth? _____

Do you use chemical tanning solutions? _____

Are you planning a holiday in the sun? _____

Are you a diabetic? _____

Have you ever had any Photo-Rejuvenation session? _____ If so, where? _____

Are you using Retin A or Renova?

Areas to be treated today: _____

Present Medications (Accutane, Asprin, Antiviral, Iron Supplements, Cold Therapy, Coumadin, drugs which may cause photosensitivity, including herbal supplements)

Please list dosage of antibiotic/Accutane and date of last dose taken:

Please list any topical medications you are using:

Source of referral

Signature _____

Date _____

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I authorize (healthcare professional's name) _____ to perform Laser/IPL treatments on _____ (patient's name) with the _____ Vbeam _____ Smoothbeam _____ GentleLASE _____ GentleYAG _____ GentleMax _____ AlexTriVantage _____ SmoothPeel _____ Ellipse I2PL _____

To treat my condition, which is called: _____

The Laser / IPL is a device that produces an intense but gentle burst of light. This light is absorbed by and causes selective heating of certain cells in your unwanted lesion. Lesions most commonly fade slowly over time as these destroyed cells are eliminated by normal body processes.

My eyes will be covered with laser / IPL -specific safety eyewear or an opaque material to protect them from the intense light. My eyes will be closed and I will not attempt to remove the eye protection during treatment.

I have been informed of the following possible risks and complications of this procedure including but not limited to:

(Circle all that apply):

Purpura (red-purple discoloration, bruising)

Itching (hive-like response which lasts 2-3 hours to 2-3 days)

Herpes simplex virus activation

Burns, blisters, scabbing, crusting, skin color and /or textural changes

Hyperpigmentation (darkening of the skin; transient or long term))

Hypopigmentation (lightening of the skin; transient, long term or possibly permanent)

Scarring (rare, possibly permanent)

I understand that complete clearing may not be possible and will depend upon the type, age and color of the lesion. Multiple treatments may be needed for the best results.

Other methods of treating this condition have been discussed with me such that I may assess the risks and benefits of these alternative treatment methods.

If oxygen is used during my treatment, my provider will ensure that it is used safely. Oxygen supports combustion and may cause flash burns in the treatment area.

Anesthesia is usually not necessary. My provider or I may elect to use a form of topical anesthesia to reduce any discomfort during the procedure. A cryogen spray skin cooling device may be used during the procedure to decrease discomfort and protect the skin. All anesthesia options and risks will be discussed with me in advance.

I understand that immediately following the laser treatment redness, swelling, discomfort, bruising, and discoloration may develop at the treatment site. I understand that any discoloration may last 7-14 days and swelling should resolve within several days. Discomfort may be treated with the application of cool compresses or topical soothing agents.

I will be given complete instructions regarding after care of the treated area .It is important to follow

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after care instructions carefully to minimize the chance of incomplete healing, skin textural changes or scarring. Sun avoidance and /or use of a sunblock may be recommended. Tanning should be avoided.

- I have provided my past and current medical history and medications.
- I consent to the taking of photographs during the course of my laser therapy for healthcare records.
- I consent to using my photographs for medical education and /or marketing purposes.
- My name will not be used to identify these photographs.
- I am not pregnant (female patients).

I have been given the opportunity to ask questions about the procedure. My questions have been answered and I understand the information given to me.

Contraindications to the performance of this procedure have been discussed in detail with me.

I recognize that the practice of medicine is not an exact science and acknowledge that no guarantees have been made to me concerning the results of such procedures.

I have read and understood all information presented to me before signing this consent form.

Signed: _____ Date: _____

Witness: _____ Time: _____

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Previous Laser Treatment: (specify date/number of treatments/frequency/tissue response/device used, if known):

Previous Hair Removal History, if applicable:

Wax epilation _____ Mechanical epilation (plucking) _____ Electrolysis _____ Bleaching _____
Shaving _____

Frequency/and last use of above modalities:

Other type treatment: _____

Have you ever had a cosmetic peel/cosmetic procedure? Please list

FOR STAFF ONLY:

Recommendations: Discussion with provider

- _____ 1. Treatment options (testing, brown or black hair responds best, number of treatments).
- _____ 2. Client expectations: (understand need for multiple treatments, after care, possible side effects, etc).
- _____ 3. Physician consultation (If required in your state) before or after test for a treatment recommendation.
- _____ 4. Full treatment schedule process (waiting period in-between treatments, expected results,).
- _____ 5. Possible side effects (hyperpigmentation, hypopigmentation, purpura, scarring, textural changes, burns, blistering, pain or discomfort and erythema) and length of time to expect healing if side effects occur.
- _____ 6. Specifics of area to be treated. Test small area for tissue response BEFORE full treatment.
- _____ 7. Importance of sun exposure avoidance and the use of a broad spectrum zinc oxide or titanium dioxide UVA/B sun block with SPF 30 or higher during the entire treatment program.
- _____ 8. Sensation of the laser/DCD spray and the option for topical anesthesia or other cooling methods.
- _____ 9. Benefits of laser treatment (possible long-term hair removal),
- _____ 10. Cost of treatment (payment schedule, cost of multiple treatments versus single payment per visit).
- _____ 11. Eyewear protection and laser safety measures required for patient and provider. Patients may sense light while wearing proper eye protection.
- _____ 12. Importance of post care instructions/procedures.

Photo taken today: YES _____ NO _____

COMMENTS: _____

I agree that the information listed above has been reviewed and presented with my clear understanding of what this procedure involves. All of my questions have been addressed to my satisfaction.

Signed: _____ Date: _____

Witness: _____ Date: _____