Medical History Form

GENERAL

Are you currently under the care of a physician?

○ Yes ○ No If yes, please note:_____

Are you currently under the care of a dermatologist?

○ Yes ○ No If yes, please note:_____

Do you have a history of a persistent skin rash produced by prolonged or repeated exposure to sunlight radiation?

○ Yes ○ No

Do you have any of the following medical conditions?

○ Cancer
○ Diabetes
○ High blood pressure
○ Herpes
○ Arthritis
○ Frequent cold sores
○ HIV /AIDS
○ Keloid scarring
○ Skin disease/Skin lesions
○ Seizure disorder
○ Hepatitis
○ Hormone imbalance
○ Thyroid imbalance
○ Blood clotting abnormalities
○ Any active infection
○ Psoriasis / Vitiligo / Lupus
○ G6PD deficiency

Do you have any other health problems or medical conditions? Please note: _____

_____

_____

_____

Have you ever had an allergic reaction to any of the following? (Describe the reaction you experienced) ○ Food ○ Latex ○ Aspirin ○ Lidocaine ○ Hydrocortisone ○ Hydroquinone or skin bleaching agents ○ Aloe Vera ○ Others:_____

_____

_____

_____

MEDICATIONS

What oral medications are you presently taking?

○ Birth control pills ○ Hormones ○ Anticoagulants ○ Aspirin ○ Analgesics ○ Anti-inflammatory ○ Anti-epileptics ○ Antibiotics ○ Insulin ○ High blood pressure drugs

○ Others (please note):_____.

Are you on any mood altering or anti-depression medication? ○ Yes ○ No

Have you ever used Accutane? ○ Yes ○ No. If yes, when did you last use it?_____

What topical medications or creams are you currently using?

○ Retin A ○ Others (please note): _____

_____

What herbal supplements (or vitamins [especially vitamin A]) do you use regularly? _____

_____

HISTORY

Have you ever had light-based treatments? ○ Yes ○ No

Have you used any of the following hair removal methods in the past six weeks?

○ Shaving ○ Waxing ○ Electrolysis ○ Plucking ○ Tweezing ○ Stringing ○ Depilatories

Have you had any recent tanning or sun exposure that changed the color of your skin?

○ Yes ○ No

Is your usual work environment out-of-doors? ○ Yes ○ No

Have you recently used any self-tanning lotions or treatments? ○ Yes ○ No

Do you form thick or raised scars from cuts or burns? ○ Yes ○ No

Do you have hyperpigmentation (darkening of the skin) or hypopigmentation (lightening of the skin) or marks after physical trauma? ○ Yes ○ No

If yes, please describe: _____

_____

FEMALE PATIENTS

Are you pregnant or trying to become pregnant? ○ Yes ○ No

Are you breastfeeding? ○ Yes ○ No

Are you using contraception? ○ Yes ○ No

I certify that the preceding medical, personal and skin history statements are true and correct. I am aware that it is my responsibility to inform the technician, esthetician, therapist, doctor or nurse of my current medical or health conditions and to update this history form should any changes occur during my treatment regimen. A current medical history is essential for the caregiver to execute appropriate treatment procedures.

Signature: _____ Date: _____

*All patients must sign a consent form before any treatment.

Consent Form

For Hair Reduction, Skin Rejuvenation, Pigmented lesions, Vascular lesions and Acne.

Name: _____ Date: _____

I authorize you to perform a Pulsed Light System procedure.

I am aware that these treatments are intended to result in hair reduction, skin rejuvenation, or improvement of pigmented and vascular lesions and acne.

I understand and accept that it is necessary to conduct more than one treatment in order to achieve results. I also accept that it may be necessary to use other manners of treatments, including skin care products, needed to blend color, reduce sun damage and more.

The skin treated will be red and swollen for a period of time, with the forming of fine, thin scabs. Keep the treated areas covered with Aloe Vera gel and soothing creams until the thin scabs fall off. This process will take between 1-3 weeks. It could take as long as 3-6 months in some rarer cases. Do not scratch the scabs, as scarring may result.

We are unable to treat clients who are taking ACCUTANE and PHOTOSENSITIZING medications.

Client must fill in a medical history form which must be updated if any changes occur during the treatment period.

The following problems may occur with treatment:

1. Scarring: The pulsed light system can create a bruising and a moderate burn or blister to the skin. For an effective treatment, the intensity (joules) must be just below the blistering point which means that the skin will be red (erythema).

There is a risk of scarring in burned skin cases.

2. Hyperpigmentation and hypopigmentation have been noted to occur after treatments, especially with a darker complexion. This usually resolves within weeks, but it can take as long as 3-6 months in some cases. Permanent color change is a rare risk. If you have dark skin, a skin lightening cream may be advised to reduce the melanin in your skin before the treatment. Avoiding sun exposure before and after the treatment is crucial to reduce the risk of color change and burns.

3. Infection: Although infection following pulsed light treatment is unusual, bacterial, fungal, and viral infections can occur. Herpes simplex virus infections around the mouth can occur following a treatment. This applies to individuals with a past history of Herpes simplex virus infections in the area. Should any type of skin infection occur, additional treatment including antibiotics will be necessary.

If you have a history of Herpes simplex virus in the treated area we recommend preventive therapy.

4. Bleeding: Pinpoint bleeding is rare but can occur following pigmented and vascular lesion treatment procedures. Should bleeding occur, additional treatment might be necessary.

5. Skin tissue pathology: Energy directed at skin lesions may potentially vaporize the lesion. Laboratory examination of the tissue specimen may not be possible. Only clearly benign pigmented lesions can be treated. Check with your doctor for a clearance for the treatment.

6. Allergic reactions: In rare cases, local allergies to tape, preservatives used in cosmetics or topical preparations have been reported. Systemic reactions (which are more serious) may result from prescription medicines. Allergic

reactions may require additional treatment.

7. Wear sunscreen of SPF 50 or higher before and after treatment to protect your skin. We highly recommend you use sunscreen at all times.

8. I understand that exposure of my eyes to light could harm my vision. I will keep the eye protection on at all times during the treatment session.

9. Compliance with the after care guidelines is crucial for healing, prevention of scaring, hyper-pigmentation and hypopigmentation. Occasionally, unforeseen mechanical problems may occur and your appointment will need to be rescheduled. We will make every effort to notify you prior to your arrival to the office. Please be understanding if any inconveniences occur.

ACKNOWLEDGEMENT

My questions regarding the procedure have been answered satisfactorily. I understand the procedure and understand the risks. I hereby release (individual) and (facility) and (doctor) from all liabilities associated with the above indicated procedure.

Client/Guardian Signature _____

Date _____

Practitioner Signature _____

Date _____