

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?

- | | |
|---|--|
| <input type="radio"/> Cancer | <input type="radio"/> Seizure disorder |
| <input type="radio"/> Diabetes | <input type="radio"/> Hepatitis |
| <input type="radio"/> High blood pressure | <input type="radio"/> Hormone imbalance |
| <input type="radio"/> Herpes | <input type="radio"/> Thyroid imbalance |
| <input type="radio"/> Arthritis | <input type="radio"/> Blood clotting abnormalities |
| <input type="radio"/> Frequent cold sores | <input type="radio"/> Any active infection |
| <input type="radio"/> HIV /AIDS | <input type="radio"/> Psoriasis / Vitiligo / Lupus |
| <input type="radio"/> Keloid scarring | <input type="radio"/> G6PD deficiency |
| <input type="radio"/> Skin disease/Skin lesions | |

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 PHOTSENSITIZING 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 scarring, 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 _____