MEDICAL HISTORY FORM

Last Name: ______________________ First Name: ______________________

Address: ____

City: ______________ State: __________ Zip Code: ____________

Telephone: Home: __________ Work: __________ Cell: ____________

Date of Birth: ____________ Sex: Female ____ Male ____

Family Doctor: ______________________ Phone: ____________

Pharmacy: ______________________ Phone: ____________

Emergency Contact: ______________________ Phone: ____________

Which body area/areas or condition would you like treated? ____________

____

____

Please answer all of the following questions **YES NO**

1. Do you have **ANY** current or chronic medical illnesses? ○ ○
Disclose any history of heat urticaria, diabetes, autoimmune disorders or any immunosuppression, blood disorders, cancer, bacterial or viral infections, medical conditions that significantly compromise the healing response, skin photosensitivity disorders, or any other condition or illness.
Please List: ____
____

2. Do you have **ANY** current or chronic skin conditions? ○ ○
Also disclose any history of vitiligo, eczema, melasma, psoriasis, allergic dermatitis, any diseases affecting collagen including Ehlers-Danlos syndrome, scleroderma, skin cancer, or any other skin condition.
Please List: ____
____

3. Are you currently under a doctor's care? If so, for what reason? ○ ○
____

4. Do you take/use **ANY** medications (prescriptions and nonprescriptions), vitamins, herbal or natural supplements, on a regular or daily basis? ○ ○
Please List: ____
____

5. Are there any topical products (both medical and non-medical) that you use on your skin on a regular or daily basis? ○ ○
Please List: ____

6. Do you take/use ANY systemic/oral steroids (e.g., prednisone, dexamethasone)? ○ ○
7. Do you have **ANY** allergies to medications, foods, latex or other substances? ○ ○
Please List: ____
8. (For women) are you or could you be pregnant? ○ ○
9. (For women) are menstrual periods irregular, or have you ever been diagnosed with Polycystic Ovarian Disorder? ○ ○
10. Do you have a history of herpes I or II in the area to be treated? ○ ○
11. Do you have a history of keloid scarring or hypertrophic scar formation? ○ ○
12. Do you have a history of light induced seizures? ○ ○
13. Do you have any open sores or lesions? ○ ○
14. Do you have any history of radiation therapy in the area to be treated? ○ ○

MEDICAL HISTORY, CONTINUED

	YES	NO
15. In the last six (6) months, have you used any of the following: anticoagulants or blood-thinning medications; photosensitizing medications; or anti-inflammatory or blood thinning medications? Please List product name and date last used: ______	O	O
16. In the last three (3) months, have you used any of the following products: glycolic acid or other alphahydroxy or betahydroxy acid products; exfoliating or resurfacing products or treatments? Please List product name and date last used: ______	O	O
17. Do you have or have you ever had any permanent make-up, tattoos, implants, or fillers,including, but not limited to, collagen, autologous fat, Restylane®, etc.? If yes, please list locations on or in the body and dates: ______	O	O
18. Do you have or have you ever had any Botulinums, such as Botox® or Dysport®? If yes, please list locations on or in the body and dates: ______	O	O
19. Have you taken Accutane® (or products containing isotretinoin) in the last 12 months?	O	O
20. Have you taken Tretinoin (like Retin-A, Renova) in the last 6 months?	O	O
21. Have you had any unprotected sun exposure, used tanning creams (including sunless tanning lotions) or tanning beds or lamps in the last 4-6 weeks?	O	O
22. Do you have a pacemaker?	O	O

Please include your email address to receive appointment confirmations, and monthly information on special pricing and/or special events:

______@______

How did you hear about us? ______

Signature: ______ Date: ______

I request and authorize Dr. ______________________________ to perform a procedure on me known as: ______________________________ using the SmartSkin CO_2 laser.

The nature and effects of the procedure, the risks, ramifications, complications involved, as well as alternative methods of treatment have been fully explained to me by the physician or designated person and I understand them.

I have been thoroughly and completely advised regarding the objectives of the procedure. I understand that the practice of medicine and surgery is not an exact science and no results have been guaranteed. I acknowledge that imperfections might result and that the operative result may not reach my expectations. I certify that no guarantees have been made by anyone regarding the procedure(s) that I have requested and authorized. I understand that in the unlikely case where an imperfection results, the patient and doctor may determine the necessity of a secondary procedure and such revisions are not included in the initial surgical facility or anesthesia fee, but they will be billed at a lesser rate.

I understand that I may be required to wear the garment continuously for the number of days determined by the surgeon(s); removal is only permitted to wash and apply sterile dressing to the treatment area or take a shower.

I understand that possible adverse effects may include bleeding, infection, scarring, skin contour irregularities, asymmetry, surgical shock, pulmonary complications, skin loss, seroma, allergic reactions, and anesthesia related complications. These may occur and have been discussed and understood. I understand the importance of pretreatment and posttreatment instructions and that the failure to comply with these instructions may increase the possibility of complications.

I recognize that during the course of the operation unforeseen conditions may necessitate additional or different procedures other than those above. I therefore further authorize and request that the above named surgeon(s) perform the procedures that are, in his professional judgment, necessary and desirable.

I understand that local and/or tumescent anesthesia is normally required when liposuction is performed. I consent.

Photographs will be taken of the region of treatment. I give permission for these photographs to be used for the purposes of professional publications, training, educational, or sales purposes. If I do not agree to being photographed, it will in no way affect my present or future care. I agree to have photographs taken as a part of this study as described in this form ☐ Yes ☐ No.

I certify that I have read the above authorization, that the explanations referred to therein were made to my satisfaction, and that I fully understand such explanations and the above authorization.

Signed: ______________________________ Date: ________________

(Patient or person authorized to consent for the patient)

Witness: ______________________________ Date: ________________

Skin Typing

One of the parameters for the success of your laser treatment is the correct typing of your skin.

Skin type is often categorized according to the Fitzpatrick skin type scale which ranges from very fair (Skin Type I) to very dark (Skin type IV). The two main factors that influence skin type are genetic disposition and reaction to sun exposure and tanning habits. Skin type is determined genetically along with the color of your hair and eyes. The way your skin reacts to sun exposure is the second component in assessing your skin type. Finally, your tanning habits and exposure to the sun (past and future) are very important in the proper evaluation of your skin type.

Please take a moment to complete this essential questionnaire:

Score *(please circle)*	0	1	2	3	4
What is your eye color?	light blue, gray, green	blue, gray or green	blue	dark brown	brownish black, hazel
What is your natural hair color?	sandy red	blonde	chestnut or dark blonde	dark brown	black
What is your skin color? (non-exposed areas)	reddish	very pale	pale with beige tint	light brown	dark brown
Do you have freckles?	many	several	few	incidental	none
			Genetic Disposition	**SCORE:**	
Score *(please circle)*	0	1	2	3	4
What happens when you stay too long in the sun?	painful redness, blistering, peeling	blistering followd by peeling	burns sometimes followed by peeling	rare burns	never had burns
To what degree to you turn brown?	hardly or not at all	light color tan	resonable tan	tan very easily	turn dark brown quickly
Do you turn brown within several hours after sun exposure?	never	seldom	sometimes	often	always
How does your face react to the sun?	very sensitive	sensitive	normal	very resistant	never had a problem
			Reaction to sun exposure	**SCORE:**	
Score *(please circle)*	0	1	2	3	4
When did you last tan?	more than three months ago	2 to 3 months ago	1 to 2 months ago	less than 1 month ago	less than 2 weeks ago
Did you expose the area to be treated to the sun?	never	hardly ever	sometimes	often	always
			Tanning Habits	**SCORE:**	

Summary		**Skin Type Score**	**Fitzpatrick Skin Type**
Total score for:		0 to 7	**I**
Genetic disposition	+	8 to 16	**II**
Reaction to sun exposure	+	17 to 25	**III**
Tanning habits	+	26 to 30	**IV**
Skin Type Score:	=	Over 30	**V- VI**

Patient Name:______________________________ Date:______________