Tighter Lines
AESTHETICS

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? O O

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 <u>any</u> other condition or illness.

Please List: _____

_____

2. Do you have **ANY** current or chronic skin conditions? O O

Also disclose any history of vitiligo, eczema, melasma, psoriasis, allergic dermatitis, any diseases affecting collagen including Ehlers-Danlos syndrome, scleroderma, skin cancer, or <u>any</u> other skin condition.

Please List: _____

_____

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

_____

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

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? O O

Please List: _____

6. Do you take/use ANY systemic/oral steroids (e.g., prednisone, dexamethasone)? O O
7. Do you have **ANY** allergies to medications, foods, latex or other substances? O O

   Please List: _____
8. (For women) are you or could you be pregnant? O O
9. (For women) are menstrual periods irregular, or have you ever been diagnosed with Polycystic Ovarian Disorder? O O
10. Do you have a history of herpes I or II in the area to be treated? O O
11. Do you have a history of keloid scarring or hypertrophic scar formation? O O
12. Do you have a history of light induced seizures? O O
13. Do you have any open sores or lesions? O O
14. Do you have any history of radiation therapy in the area to be treated? O O

_____

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? O O
Please List product name and date last used: _____

_____

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? O O
Please List product name and date last used: _____

_____

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.? O O
If yes, please list locations on or in the body and dates: _____

_____

18. Do you have or have you ever had any Botulinums, such as Botox® or Dysport®? O O
If yes, please list locations on or in the body and dates: _____

_____

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: _____

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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:_____

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AESTHETICS

Informed Consent for Hair Removal

Patient Name:_____ Date:_____

Treatment sites: mono-brow, lip, chin, neck, face, arms, fingers, chest, areola, linea, underarms, back, buttocks, bikini, labia, scrotum, thighs, lower, feet and toes.

Combinations:_____

Previous hair removal methods:_____
(shaving, tweezing, waxing, depilatories, electrolysis, laser)

The purpose of this procedure is to diminish or remove unwanted hair. The procedure requires more than one treatment and may produce permanent hair removal. The total number of treatments will vary between individuals. On occasion there are patients that do not respond to treatments. The treated hair should exfoliate or push out in approximately 2-3 weeks.
Alternate methods are waxing, shaving, electrolysis and chemical epilation.

1. However, **there is a risk or scarring**.
2. **Short-term effects may include reddening, mild burning, and temporary bruising or blistering. Hyper-pigmentation** (browning) and **hypo-pigmentation** (lightening) have also been noted after treatment. These conditions usually resolve within 3-6 months, **but permanent color change is a rare risk.** Avoiding sun exposure before and after the treatment reduces the risk of color change.
   Infection: Although infection following treatment is unusual, bacterial, fungal and viral infections can occur. Herpes simplex virus infections around the mouth can occur following treatment. This applies to both individuals with a past history of herpes simplex and individuals with no known history of herpes simplex virus infections in the mouth area. Should any type of skin infection occur, additional treatments or medical antibiotics may be necessary.
3. **Bleeding:** Pinpoint bleeding is rare but can occur following treatment procedures. Should bleeding occur, additional treatment may be necessary.
4. **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 medications.
5. I understand that exposure of my eyes to light could harm my vision. I must keep the eye protection goggles on at all times.
6. Compliance with the aftercare guidelines is crucial for healing, prevention of scarring, and hyper-pigmentation.

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 in the office. Please be understanding if we cause you inconvenience.

ACKNOWLEDGMENT:

My questions regarding the procedure have been answered satisfactorily. I understand the procedure and accept the risks. I hereby release Ocean Med Spa as well as Dr. Robert Fier from all liabilities associated with the above procedure.

Patient/ Guardian Signature:_____ Date:_____

CME:_____ Physician:_____ Date:_____