1410 Blanding Street Ste. 203
Columbia, SC 29201
(803) 851-3459

Laser Treatment Consultation Form

Name _____ Date _____ Age _____ Sex_____

Address _____

City_____ State _____ Zip Code_____

Home _____ Work _____ Cell _____

Email Address _____

Birthdate_____

Emergency Contact Name and Phone Number _____

How did you hear about us? _____

Area(s) to be treated today_____

Please list past or present medical conditions, illnesses, or allergies:

_____

_____

Present Medications (i.e. Accutane, antibiotics, aspirin, antiviral, iron supplements, Gold therapy, Coumadin, fish oils, herbal supplements, prescribed topical creams) - Please list all medications, dosages, and date last taken:

_____

_____

Do you have a history of any autoimmune disease? (i.e. Diabetes, Lupus, Rheumatoid Arthritis, Celiac) If so, please list _____

Do you have any tattoos? If so, please list location(s):_____

Are you or could you be pregnant? Yes _____ No _____ N/A _____

Do you have a history of keloids/hypertrophic scars? Yes _____ No _____

Tanning history (direct sun, self-tanners, spray tans) – Please list and include last date of use:

_____

_____

Previous Laser Treatment(s) - If known, please specify date, number of treatments, frequency, response to treatment, device used: _____

_____

_____

Previous hair removal history, if applicable:

Waxing _____ Plucking_____ Electrolysis _____ Bleaching _____ Shaving _____
Frequency and last use of above _____

_____

Have you ever had a cosmetic peel or any other cosmetic procedure? If so, please list and include date of last treatment: _____

_____

Do you have a history of skin cancer or mole removal? Yes _____ No _____

Do you suntan? Yes _____ No _____

Do you use sunscreen? Yes _____ No _____

Do you smoke? Yes _____ No _____

Continue to next page.

Please list the brand of products you are currently using, if applicable:

Cleanser _____ Toner _____ Moisturizer _____

Eye Cream _____ Mask or Scrub _____ Sunscreen _____

Other_____

Have you ever used skin lightener or Retin-A? Yes _____ No _____
If yes, please list date of last usage _____

Please circle any of the following skin concerns you may have:

Wrinkles	Skin Tone	Acne
Scarring	Black Heads	White Heads
Spider Veins	Rosacea	Hard Bumps Under the Skin
Ingrown Hairs	Other:_____	

I agree that the all of information listed above will be reviewed and presented with my clear understanding of what this procedure involves. All of my questions will be addressed.

Signature _____ Date _____

Esthetician Signature _____ Date_____

Continue to next page.

Skin Typing Evaluation and Patient Evaluation Form

This information will help your esthetician to better evaluate your skin type so that your laser treatment will be more effective. Skin type is determined genetically and includes the color of your eyes, hair, etc. The way your skin responds to sun exposure is another way of correctly assessing your skin type. Recent tanning, whether by sun or an artificial tanning booth, even tanning creams, can have a major impact on your skin.

Genetic Disposition (circle the description that best fits you):

Score	0	1	2	3	4
Natural Eye Color	Light Blue, Green, or Gray	Blue, Gray, or Green	Blue	Dark Brown	Brownish Black
Natural Hair Color	Sandy, Red	Blonde	Dark Blonde	Dark Brown	Black
Color of non-exposed Skin	Reddish	Very Pale	Pale w/Beige Tint	Light Brown	Dark Brown
Do you have freckles on unexposed skin?	Many	Several	Few	Incidental	None

Total score for genetic disposition (add all circled numbers): _____

Continue to next page.

Reaction to Sun Exposure (circle the reaction that most applies to you):

Score	0	1	2	3	4
What happens when you stay in the sun for a prolonged time?	Painful redness, blistering, peeling	Blistering, followed by peeling	Burn sometimes, followed by peeling	Rarely burn	Never burn
Degree that you turn brown	Hardly or not at all	Light color tan	Reasonably 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

Total score for reaction to sun exposure (add all circled): _____

Tanning Habits (circle the habit that most applies to you):

Score	0	1	2	3	4
When did you last expose your body to sun or tanning booth or tanning cream(s)?	More than 3 months ago	2-3 months ago	1-2 months ago	Less than one month ago	Less than 2 weeks ago
Have you exposed the area being treated today to the sun?	Never	Hardly ever	Sometimes	Often	Always

Total score for tanning habits (add all circled): _____

On the next page you will be asked to add up these scores to get your total score and skin type.

Summary:

_____ Score for genetic disposition

_____ Score for reaction to sun exposure

_____ Score for tanning habits

_____ **Total skin type score**

Skin Type Score	Fitzpatrick Skin Type
0-7	I
8-16	II
17-25	III
26-30	IV
Over 30	V-VI

Signature _____ Date: _____

Esthetician Signature_____ Date: _____

Continue to next page.

Laser Hair Removal Policy and Guideline Consent

I, _____, am aware that there is a specific guideline for laser hair removal at Columbia Laser & Aesthetics that I will need to follow as listed below to obtain permanent hair reduction.

Please thoroughly read and <u>initial</u> beside each statement:

_____I understand that my esthetician recommends a *minimum* of **9** laser hair removal treatments per area for all patients (regardless of any previous treatments at another facility) for best results. I understand that laser treatments are sold in packages of 3.

_____I understand that only after I have paid for and received **all 9** treatments per area at Columbia Laser & Aesthetics am I eligible to receive a *maximum* of **3** complimentary follow up appointments.

_____I understand that to see optimum results I will need to stay on a consistent schedule as advised by my esthetician (typically 4 weeks for smaller body parts, or 8 weeks for larger body parts) I am aware that if I do not stay on the schedule my esthetician recommends, I will not see results.

_____I understand that I am **not** to have any prolonged exposure to the sun or use any form of tanning (including self-tanners, spray tans, and tanning beds) 2 weeks before and/or 2 weeks after each of my scheduled appointment dates. I am aware that failure to avoid sun or tanning can result in adverse reactions such as hyper/hypopigmentation and/or burning of the exposed area(s).

_____I understand that I will not be able to have laser hair removal treatments if I have been on an antibiotic or have been taking any medications with a photo/sun-sensitivity within the past 10 days (you will need to be scheduled for 10 days after the last day of taking such medications).

**Please note, if you have any questions you may ask your esthetician during your scheduled appointment time.*

Signature_____ Date _____

Continue to next page.

Laser Treatment Consent Form

Please read and initial by each paragraph:

_____ I am 18 years of age or older, or I am accompanied by a parent or legal guardian who will consent for me to have this treatment.

_____ I acknowledge that the laser is a device that produces an intense but gentle burst of light. With this light, there is a minimal amount of risk. These risks (listed below) are typically associated with prolonged exposure to sunlight or use of a prohibited medication.

_____ I understand that the following are possible risks and complications of this procedure including but not limited to:

- Purpura (red-purple discoloration, bruising)
- Itching (hive-like response which lasts 2-3 hours to 2-3 days)
- Herpes simplex virus activation (**only if you are already a carrier**)
- 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 my eyes will be covered with laser-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 understand that complete clearing of my spider veins, brown spots, or redness may not be possible and will depend upon the type, age and color of the trouble spot. Multiple treatments may be needed for the best results.

____ I understand that other methods of treating this condition will be discussed with me if I request, such that I may assess the risks and benefits of these alternative treatment methods.

____ I understand that 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 if I choose to use.

____ I understand that immediately following the laser treatment redness, swelling, discomfort, whelping, 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 understand I will be given complete instructions regarding after care of the treated area. It is important to follow aftercare instructions carefully to minimize the chance of incomplete healing, skin textural changes or scarring. This includes, but is not limited to, avoiding sun exposure and tanning.

Continue to next page.

_____I have answered all questions about medical history and medications honestly and completely.

_____I am not pregnant (female patients).

_____I understand I will be given the opportunity to ask questions about the procedure and the procedure will be 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.

Signature: _____Date:_____

Esthetician Signature: _____Date:_____

FOR OFFICE USE ONLY:

_____ (patient's name), authorizes Angela Heaton, LE and/or other certified laser technicians to perform Laser treatments with the ___Vbeam _____GentleLASE _____GentleYAG to treat the condition, which is called: _____.

I have reviewed this client's information. I believe him/her to be a candidate for the above recommended plan of care to be performed by Angela Heaton, LE and/or other certified laser technicians.

Signed: _____MD
Date:_____