LASER CONSULTATION FORM

Name ____Age ______Sex___ Date_________________

Area(s) to be treated today:____
____

Past or present Illnesses/Medical Conditions, please list:

Allergies:
____
____

Present Medications (Accutane, Antibiotics, Aspirin, Antiviral, Iron supplements, Gold therapy, Coumadin, drugs which may cause photosensitivity this includes herbal supplements):
List medications and dosages:
____
____
____

Please list dosage of oral antibiotics/Accutane and date of last dose taken:
____
____

Please list any topical medications you are using:
____
____

Do you have a history of any autoimmune disease? ________________________________
Do you have a history of HSV I or HSV 2 ____

Do you have any implants/injectables/permanent make-up? If so, please list:
____

Do you have any tattoos? Is so, please list location:
____

Are you pregnant? Yes_______ No__________N/A_________LMP____________

History of keloids/hypertrophic scars: yes____ no______
Tanning history (including direct sun, self tanners, spray tans) Please list and include last date of use:
____

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Previous Laser Treatment: (specify date/number of treatments/frequency/tissue response/devise used, if known):
____
____
____
____

Previous Hair Removal History, if applicable:
Wax epilation ______ Mechanical epilation (plucking) _____ Electrolysis _____ Bleaching _____ Shaving__

Frequency/and last use of above modalities:
____
Other type treatment: ____
Have you ever had a cosmetic peel/cosmetic procedure? Please list

____

FOR STAFF ONLY:

Recommendations: Discussion with provider
_____1. Treatment options (testing, brown or black hair responds best, number of treatments).
_____2. Client expectations: (understand need for multiple treatments, after care, possible side effects, etc).
_____3. Physician consultation(If required in your state) before or after test for a treatment recommendation.
_____4. Full treatment schedule process (waiting period in-between treatments, expected results.,
_____5. Possible side effects (hyperpigmentation, hypopigmentation, purpura, scarring, textural changes,burns,blistering, pain or discomfort and erythema) and length of time to expect healing if side effects occur.
_____6. Specifics of area to be treated. Test small area for tissue response BEFORE full treatment.
_____7. Importance of sun exposure avoidance and the use of a broad spectrum zinc oxide or titanium dioxide UVA/B sun block with SPF 30 or higher. during the entire treatment program.
_____8. Sensation of the laser/DCD spray and the option for topical anesthesia or other cooling methods.
_____9. Benefits of laser treatment (possible long-term hair removal),
_____10. Cost of treatment (payment schedule, cost of multiple treatments versus single payment per visit).
_____11. Eyewear protection and laser safety measures required for patient and provider. Patients may sense light while wearing proper eye protection.
_____12. Importance of post care instructions/procedures.

Photo taken today: YES____ NO____
COMMENTS: ____
____

I agree that the information listed above has been reviewed and presented with my clear understanding of what this procedure involves. All of my questions have been addressed to my satisfaction.
Signed: ____ Date: ______________________
Witness: ____ Date: _________________________