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 <u>any</u> 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 <u>any</u> 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. Have you ever had Gold Therapy Treatment (chrysotherapy, aurotherapy, Gold sodium thiomalate (GST)?	☐	☐
6. Are there any topical products (both medical and non-medical) that you use on your skin on a regular or daily basis? Please List: _____		

MEDICAL HISTORY, CONTINUED

		YES	NO
7.	Do you take/use ANY systemic/oral steroids (e.g., prednisone, dexamethasone)?	☐	☐
8.	Do you have **ANY** allergies to medications, foods, latex or other substances?	☐	☐
	Please List: _____		
9.	(For women) are you or could you be pregnant?	☐	☐
10.	(For women) are menstrual periods regular, or have you ever been diagnosed with Polycystic Ovarian Disorder?	☐	☐
11.	Do you have a history of herpes I or II in the area to be treated?	☐	☐
12.	Do you have a history of keloid scarring or hypertrophic scar formation?	☐	☐
13.	Do you have a history of light induced seizures?	☐	☐
14.	Do you have any open sores or lesions?	☐	☐
15.	Do you have any history of radiation therapy in the area to be treated?	☐	☐
16.	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: _____		
	_____		
17.	In the last three (3) months, have you used any of the following products: glycolic acid or otheralphahydroxy or betahydroxyacid acid products; exfoliating or resurfacing products or treatments?	☐	☐
	Please List product name and date last used: _____		
	_____		
18.	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: _____		
	_____		
19.	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: _____		
	_____		
20.	Have you taken Accutane® (or products containing isotretinoin) in the last 12 months?	☐	☐
21.	Have you taken Tretinoin (like Retin-A®, Renova®) in the last 6 months?	☐	☐
22.	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?	☐	☐

Signature:_____Date: _____

CONSENT FOR LASER/LIGHT BASED TREATMENT

I authorize_____to perform laser/pulsed light cosmetic skin treatments on me, including, but not limited to, the treatment of pigmented lesions (for example, sun spots, age spots, and other skin discolorations), vascular lesions (for example, red spots, leg veins and small spider veins, but not varicose veins), wrinkles, (rhytides), furrows, fine lines, textural irregularities, non-ablative skin resurfacing, soft tissue coagulation, ablative skin resurfacing, and reducing or eliminating hair. I understand that the procedure is purely elective, that the results may vary with each individual, and multiple treatments may be necessary.

I understand that:

- The Cynosure Icon™ Aesthetic System is a pulsed-light and laser system that delivers a precise pulse of light energy that is absorbed by a chromophore in skin, for example, hemoglobin in the blood or pigment in a lesion, causing a thermal reaction. All personnel in the treatment room, including me, must wear protective eyewear to prevent eye damage from this light energy.
- The sensation of light is sometimes uncomfortable and may feel like a moderate to severe pinprick or flash of heat. Anesthesia or sedation (calming medication) may be advisable for laser skin resurfacing treatments. If the practitioner or physician elects to use an anesthetic to reduce discomfort during any light-based treatment, all options and risks associated with the anesthetic will be discussed with me.
- The treated area may be red and swollen for two to twenty-four (2–24) hours or longer. Cooling the area after the treatment (for example, ice packs, topical gels) may help reduce discomfort and swelling.
- Common side effects include temporary redness (erythema) or mild "sunburn"-like effect that may last a few hours to 3-4 days or longer. Other potential side effects include, but are not limited to, crusting, irritation, itching, pain, burns, scabbing, swelling (edema), broken capillaries, bronzing, and acne or herpetic breakouts. There also is a risk of resulting unsatisfactory appearance and failure to achieve the desired result.
- Pigment changes, including hypopigmentation (lightening of the skin) or hyperpigmentation (darkening of the skin), lasting one to six (1-6) months or longer or permanently may occur. Freckles may temporarily or permanently disappear in treated areas.
- Serious complications are rare but possible, such as, scarring, blood clots, skin loss, hematomas (collection of blood under the skin), and allergic reaction to medications or materials used during the procedure.
- I understand and accept that with skin resurfacing treatments, there may be an increased length of social downtime associated with the level of treatment. There also is a chance of additional side effects like blanching and significant redness.
- With ablative laser treatments, there are additional risks of discomfort, focal areas of bleeding, bruising, poor healing, serous discharge, and infections. Serious but rare complications may include scarring, abscess, skin necrosis (dead skin), and injury to other internal structures including nerves, blood vessels, or muscles.
- An occlusive ointment may be used to cover the treated skin and keep it moist to avoid the skin drying out and being crusty or desquamated. Occlusion may exacerbate acne breakouts under the ointment.
- There is no guarantee that the expected or anticipated results will be achieved.

CONSENT FOR LASER/LIGHT-BASED TREATMENT, CONTINUED

- Sun, tanning bed, or tanning lamp exposure, the use of self-tanning creams, and not adhering to the post-treatment instructions provided to me may increase my chance of complications. I must avoid the sun, tanning beds, and sunless tanning lotions and use sunblock (SPF 45 recommended) after treatment.
- There is a possibility of coincidental hair removal when treating pigmented or vascular lesions in hair-bearing areas. There is a risk that the hair regrowth may be changed, such as little or no regrowth or more regrowth than before.
- I should call my provider as soon as possible if I have any concerns about side effects or complications after treatment.
- I hereby consent to the administration of any anesthesia or sedation considered necessary or advisable for my procedure(s). I understand that all forms of anesthesia and sedation involve risk and the possibility of complications, injury, and in rare instances death.
- Not providing my medical history before proceeding with a light-based treatment could impact treatment results and cause complications.

I consent to photographs and digital images being taken and used to evaluate treatment effectiveness, for medical education, training, professional publications or sales purposes. No photographs or digital images revealing my identity will be used without my written consent. If my identity is not revealed, these photographs and digital images may be used, shared, and displayed publicly without my permission.

Before and after-treatment instructions have been discussed with me. The procedure, potential benefits and risks, and alternative treatment options have been explained to my satisfaction.

I have read and understand all information presented to me before consenting to treatment. I have had all my questions answered.

I freely consent to the proposed treatment today as well as for future treatments as needed.

Signature:_____Date _____

Print name: _____

Witness signature:_____Date: _____

Print name: _____