Client Medical History

In order to provide the safest and most informed laser treatment, the client will need to complete the following questionnaire. Please keep your clients information strictly confidential.

PERSONAL HISTORY

Client Name _____ Today's Date _____
Date of Birth _____ Age _____ Occupation _____
Home Address _____ City _____ State ____ Zip Code _____
Home Phone (____) _____ Work Phone (____) _____
Email Address _____
Emergency Contact Name and Phone _____
How were you referred to us? _____

Which of the following best describes your skin type? (Please circle one or more if unsure)

I	Always burns, never tans
II	Always burns, sometimes tans
III	Sometimes burns, always tans
IV	Rarely burns, always tans
V	Brown, moderately pigmented skin
VI	Deeply pigmented, never burns

MEDICAL HISTORY

- Are you currently under the care of a physician or dermatologist? □ Yes □ No
- If yes, for what: _____
_____
- Do you have a history of Erythema, or Eczema or any persistent skin rash produced by prolonged or repeated exposure to moderately intense heat or infrared irritation? □ Yes □ No

- Do you have any of the following medical conditions? (Please check all that apply)
□ Hepatitis □ Cancer □ Diabetes □ Herpes □ Frequent Cold Sores □HIV/AIDS
□ Keloid Scarring □ Skin disease/Skin Lesions □ Blood Clotting Abnormalities
□ Seizure Disorder □ High Blood Pressure □ Any Active Infection

- Do you have any other health problems or medical conditions? Please list: _____
_____
_____

- Have you ever had an allergic reaction to any of the following? (Please check all that apply)
□Food□Latex□Aspirin□Lidocaine□ Coconut Oil □Other _____

Client Medical History

MEDICATIONS

- What oral medications are you presently taking?
  □ Birth control pills □ Hormones □Others (Please list): _____
- Are you on any mood altering or anxiety suppression medication? _____
- Have you ever used any prescribed oral acne medication (Accutane, Epiduo, etc.)?
  □ Yes □ No - If yes, when did you last use it? _____
- What topical medications or creams are you currently using?
  □ RetinA □Others (Please list): _____
- What herbal supplements do you use regularly? _____

HISTORY

- Have you ever had any type of laser treatments in the past? □ Yes □ No
  (Please list): _____
- How often do you drink coffee or energy drinks? _____
- Do you smoke cigarettes or tobacco regularly? □ Yes □ No
- Have you had any recent tanning or sun exposure that changed the color of your skin? □ Yes □ No
- Have you recently used any self-tanning lotions or treatments? □ Yes □ No
- Do you form thick or raised scars from cuts or burns? □ Yes □ No
- Do you have hyper pigmentation (darkening of the skin) or hypo pigmentation (lightening of the skin or marks after physical trauma)? □ Yes □ No
- If yes, please describe: _____

WOMANONLY

- Are you pregnant or trying to become pregnant? □ Yes □ No
- Are you breastfeeding? □ Yes □ No

I certify that the preceding medical, personal and skin history statements are true and correct. I am aware that it is my responsibility to inform the technician, esthetician, therapist, doctor or nurse of my current medical or health conditions and to update this history. A current medical history is essential for the caregiver to execute appropriate treatment procedures.

Signature _____ Date: _____

Informed Treatment Consent

INFORMED CONSENT FOR LASER TATTOO REMOVAL

I, _____ (Client Name) consent to and authorize _____ (Clinic Name) and members of his/her staff to perform multiple treatments, laser procedures and related services on me. The procedure planned uses laser technology for the removal of tattoos.

As a patient you have the right to be informed about your treatment so that you may make the decision whether to proceed for laser tattoo removal or decline after knowing the risks involved. This disclosure is to help to inform you prior to your consent for treatment about the risks, side effects and possible complications related to laser tattoo removal:

The following problems may occur with the tattoo removal system.

1. **The possible risks of the procedure include but are not limited to** pain, purpura, swelling, redness, bruising, blistering, crusting/scab formation, ingrown hairs, infection, and unforeseen complications which can last up to many months, years or permanently.

2. **There is a risk of scarring.**Scarring happens but is uncommon. Scarring can be permanent.

3. **Short-term effects may include reddening, mild burning, temporary bruising or blistering.** A brownish/red darkening of the skin (known as **hyper pigmentation**) or lightening of the skin (known as **hypo-pigmentation**) may occur at times up to 3-6 months, years or permanently following treatment. Loss of freckles or pigmented lesions can occur.

4. **Textual changes** in the skin can occur and can be permanent.

Informed Treatment Consent

5. **Infection:** Although infection following treatment is unusual, bacterial, fungal and viral infections can occur. Herpes simplex virus infections around the mouth can occur following a treatment. This applies to both individuals with a past history of herpes simplex virus infections 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.

6. **Bleeding:** Pinpoint bleeding is rare but can occur following treatment procedures. Should bleeding occur, additional treatment may be necessary.

7. **Allergic Reactions:** Upon dissemination, the pigments can induce a severe allergic reaction that can occur with each successive treatment. Noted in some patients are superficial erosions, bruising, blistering, milia, redness and swelling which can last up to many months, years or permanently.

8. I understand that exposure of my eyes to light could harm my vision. I **must keep the eye protection goggles on at all times**.

9. **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 to the office. Please be understanding if we cause you any inconvenience.

ACKNOWLEDGMENT:

My questions regarding the procedure have been answered satisfactorily. I understand the procedure and I accept the risks. I hereby release _____(Technician) &_____(facility)_____ (doctor) from all liabilities associated with the above-indicated procedure.

Client/Guardian Signature: _____ Date: _____

Laser Technician Signature: _____ Date: _____