



HEALTH HISTORY

To ensure both the effectiveness and the safety of your treatment, please complete this health history as accurately as you can.

PERSONAL INFORMATION

Name _____ Date _____ DOB _____ Age _____

Address _____ Sex: ___ Female ___ Male

City _____ State _____ Zip Code _____

Home Phone _____ Work _____ Mobile _____ Other _____

Email: _____

Reason for this visit? _____

How did you hear of us? Google Yahoo Dallas Voice Existing Patient Other _____

I AM INTERESTED IN: (Please check all that apply)

- HAIR REMOVAL
- SKIN TIGHTENING
- ROSACEA TREATMENT
- ACNE TREATMENTS
- CELLULITE TREATMENT
- OTHER, PLEASE SPECIFY _____
- SKIN REJUVENATION
- ACNE SCAR TREATMENT
- SUN DAMAGE / AGE SPOTS
- LASER LEG VEIN TREATMENTS
- PHOTOFACIAL
- SKIN CARE ADVICE / PRODUCTS
- MICRODERMABRASION/CHEMICAL PEELS
- FACIAL VEIN TREATMENTS
- TEETH WHITENING
- FAT/VOLUME REDUCTION

DO YOU USE SUNSCREEN YES NO IF YES, SPF # AND BRAND _____

WHEN YOU SUNBATHE, HOW DOES YOUR SKIN RESPOND?

- ALWAYS BURN, NEVER TAN
- USUALLY BURN, TAN WITH DIFFICULTY
- SOMETIMES BURN, TAN ABOUT AVERAGE
- ALMOST NEVER BURN, TAN VERY EASILY
- RARELY BURN, TAN EASILY
- NEVER BURN, ALWAYS TAN

MEDICAL HISTORY (Please circle your answer)

ACUTANE	YES	NO	HEPATITIS	YES	NO
ACNE	YES	NO	HIRSUTISM	YES	NO
ALLERGIES (drug or latex)	YES	NO	HIGH BLOOD PRESSURE	YES	NO
ARTHRITIS	YES	NO	HIV POSITIVE	YES	NO
AUTOIMMUNE DISORDER	YES	NO	KELOID SCARS (other scars)	YES	NO
BLOOD DISORDERS	YES	NO	KIDNEY DISEASE	YES	NO
CANCER (radiation therapy)	YES	NO	METAL PINS IN BODY	YES	NO
COLD SORES	YES	NO	MELANOMA	YES	NO
CONTACT LENSES	YES	NO	PACEMAKER	YES	NO
DERMATITIS/ECZEMA	YES	NO	RETIN A	YES	NO
DIABETES	YES	NO	PCOS (polycystic ovarian)	YES	NO
EPILEPSY	YES	NO	SKIN PIGMENTATION	YES	NO
GENETIAL HERPES	YES	NO	STD'S	YES	NO
HORMONAL IMBALANCE	YES	NO	Steroid or Hormonal Therapy	YES	NO
HEART CONDITION	YES	NO	SHINGLES	YES	NO
HEMOPHILIA	YES	NO	VITILIGO	YES	NO

Please Initial _____
Please fill out other side.

ADDITIONAL QUESTIONS:

1. ARE YOU CURRENTLY BEING TREATED FOR ANY CONDITIONS NOT LISTED? **YES NO** IF YES, PLEASE SPECIFY.

2. ARE YOU CURRENTLY TAKING ANY MEDICATIONS, INCLUDING HERBAL PREPARATIONS, OR MEDICAL PATCHES? **YES NO** IF YES, PLEASE SPECIFY.

3. DO YOU HAVE ANY ALLERGIES? **YES NO** IF YES, PLEASE SPECIFY.

4. HAVE YOU EVER USED (OR ARE CURRENTLY USING) RETIN A OR GLYCOLIC ACID? **YES NO** IF YES, PLEASE SPECIFY.

5. HAVE YOU EVER USED (OR ARE CURRENTLY USING) ACCUTANE? **YES NO** IF YES, PLEASE SPECIFY WHEN.

6. HAVE YOU EVER HAD A CHEMICAL PEEL? **YES NO** IF YES, PLEASE SPECIFY.

7. HAVE YOU HAD ANY LASER TREATMENTS? **YES NO** IF YES, PLEASE SPECIFY.

8. WHAT PRODUCTS ARE YOU CURRENTLY USING ON YOUR SKIN?

9. DO YOU HAVE ANY DENTAL OR ACRYLIC IMPLANTS, CROWNS OR BRIDGEWORK? **YES NO** IF YES, PLEASE SPECIFY.

10. DO YOU HAVE ANY TATTOOS OR PERMANENT MAKEUP IN THE AREA TO BE TREATED? **YES NO** IF YES, PLEASE SPECIFY.

11. DO YOU HAVE A PACEMAKER? **YES NO**

12. HAVE YOU EVER BEEN TREATED BY AN ENDOCRINOLOGIST (HORMONE IMBALANCE)? **YES NO** IF YES, PLEASE SPECIFY.

13. DO YOU SUNBATHE OR USE SELF TANNING LOTIONS OR USE TANNING BEDS? **YES NO** IF SO, THEN HOW OFTEN?

14. HAVE YOU EVER HAD GOLD THERAPY (USED FOR RHEUMATOID ARTHRITIS) **YES NO**

15. ARE YOU CURRENTLY PREGNANT OR TRYING TO GET PREGNANT? **YES NO YOU MUST INFORM US IF YOU BECOME PREGNANT DURING TREATMENTS.**

16. HAVE YOU HAD RESTYLANE, PERLANE, HYLAFORM OR BOTOX INJECTIONS IN THE AREA TO BE TREATED? **YES NO** IF YES, PLEASE SPECIFY.

17. DO YOU HAVE ANY PARTICULAR SKIN SENSITIVITIES? **YES NO** IF YES, PLEASE SPECIFY.

How soon would you like to begin treatments? Very Soon Near Future Today if Possible

Please sign below to indicate all the information on this for is accurate and complete.

Signature _____ Date _____

LASER TREATMENT PATIENT EVALUATION

This information will help our office to better evaluate your skin type so the laser treatment will be more effective. 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 VI). The two main factors that influence skin type and the treatment program devised by your practitioner are:

- **Genetic Disposition**
- **Reaction to Sun Exposure and Tanning Habits**

Skin type is determined genetically and is one of the many aspects of your overall appearance, which also 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 the sun or an artificial tanning booth, even tanning creams, can have a major impact on your skin color evaluation.

By using the information you provide on this form, we can be better prepared to provide you with the best care. Please take a few minutes to fill out this questionnaire.

Genetic Disposition

Score	0	1	2	3	4
Your natural eye color?	Light Blue, Green, or Gray	Blue, Gray or Green	Blue	Dark Brown	Brownish Black
Natural color of your hair?	Sandy, Red	Blond	Chestnut/Dark Blond	Dark Brown	Black
Color of your non-exposed skin?	Reddish	Very Pale	Pale with beige tint	Light Brown	Dark Brown
Do you have freckles on unexposed areas?	Many	Several	Few	Incidental	None

Total score for genetic disposition: _____

Reaction to Sun Exposure

Score	0	1	2	3	4
What happens when you stay too long in the sun?	Painful redness, blistering, peeling	Blistering, followed by peeling	Burns sometimes, followed by peeling	Rarely burn	Never burn
To what degree do you turn brown?	Hardly or not at all	Light color tan	Reasonable tan	Tan every easy	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: _____

Patient Evaluation: Pg. 2

Tanning Habits

Score	0	1	2	3	4
When did you last expose your body to sun or tanning booth/cream?	More than 3 months ago	2-3 months ago	1-2 months ago	Less than one month ago	Less than 2 weeks ago
Do you expose the area to be treated to the sun?	Never	Hardly ever	Sometimes	Often	Always

Total score for tanning habits: _____

Summary

Add up the total scores for each section for your Skin Type Score to give you a better evaluation of your skin type.

_____ **Total score for Genetic Disposition**

_____ **Total score for Reaction to Sun Exposure**

_____ **Total score for Tanning Habits**

_____ **Skin Type Score**

Fitzpatrick Skin Type:

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

NAME: _____ **DATE:** _____

COMMENTS: _____



Patient Consent for Laser Hair Reduction

Patient Name: _____

Procedure: Laser Hair Reduction
Lasers: Long Pulsed Alexandrite (755nm) – Candela GentleLase
Variable Pulsed Nd:Yag (1064nm) – Candela GentleYag

I hereby authorize and direct any associates or assistants of Advanced Skin Fitness to perform laser hair reduction on me. Because these treatments are effective only on actively growing hairs, **multiple treatments** will be required to achieve cosmetically acceptable results. White, gray, red, and blond hairs will not respond to laser or light based treatments. In rare cases, patients may not experience any hair reduction even with multiple laser treatments. I specifically acknowledge that no guarantees or warranties have been made concerning the results of the procedure.

The following points have been discussed with me and I understand:
(please initial each statement)

_____ **Eye protection must be worn at all times during the treatment.**

_____ I understand that the purchase of a package **does not** ensure that I will not need additional treatments.

_____ I am fully aware that my condition is of cosmetic concern and that the decision to proceed is based solely on my expressed desire to do so.

_____ I confirm that I am not pregnant at this time. I acknowledge that it is my responsibility to let my technician know if I become pregnant during treatment.

_____ I have not taken Accutane within the last 6 months. I do not have a pacemaker or internal defibrillator

_____ The most likely possible complications or risks involved with laser hair reduction include, but are not limited to blistering with infection and scarring, scabbing, bruising, and long-term pigmentary changes.. Hypopigmentation or hyperpigmentation could be permanent. Blistering, infection, scarring, scabbing, bruising, and long term pigmentary changes are more likely in people that are not honest about their tanning habits or who try to tan during the course of their treatments. **Tanned skin cannot be treated with the Alexandrite Laser Device.** I understand that it is my responsibility to let my technician know if I have received any tan throughout the course of my treatment.

_____ The presence of medical conditions that alter the hormone balance in females may limit the effectiveness of laser hair reduction.

_____ Close adherence to ideal laser schedules will improve your results. Conversely, failure to follow the laser schedule may diminish your results and in turn require more treatments than normal.

_____ Because the laser treatments will tend to synchronize the growth cycles of hair, there may be the perception of increased hair during your treatments. This usually occurs near the third or fourth treatment. Do not be alarmed.

_____ In rare cases Laser Hair Removal can stimulate dormant follicles and can actually increase hair growth.

_____ Anesthesia is usually not necessary as this laser uses a cooling device that delivers a spray to the surface of the skin to reduce discomfort when the laser pulse is delivered. Topical anesthetic creams will lessen the discomfort in sensitive areas.

_____ I hereby authorize Advanced Skin Fitness or any associates to take pictures of the treated area to be used in my patient file.

_____ I understand that immediately following the laser treatment, the treated area will appear as a red discoloration and have edema (swelling). The redness (erythema) and discoloration may take up to 6 months to heal. The treated area will feel like a sunburn for a few hours after the treatment.

_____ I have received a copy of the pre and post laser hair reduction documents. Aftercare guidelines are crucial for healing, prevention of scarring and hyperpigmentation

ACKNOWLEDGEMENT

I understand that I release Advanced Skin Fitness and its associates, the Medical Director, the laser technician performing services, and any other person involved in my treatment from any liability associated with complications from the laser procedure. I am aware that Advanced Skin Fitness has a 24 hour cancellation policy. Similarly, I will be charged \$100 for any broken appointment without 24 hour cancellation. I understand that all procedures are priced per treatment. I understand that no guarantees can be made and all payments are non-refundable. By my signature below, I certify that I have read and fully understand the contents of this permission and authorize the performance of laser hair reduction by the staff of Advanced Skin Fitness.

Patient or legal guardian signature and date _____

Witness signature and date _____

PATIENT INSTRUCTIONS FOR LASER TREATMENT

PRE-TREATMENT INSTRUCTIONS

1. Avoid the sun and tanning beds in the area to be treated for 4-6 weeks before laser treatments.
2. Wear broad spectrum sun protection with SPF 30 or higher on any exposed treatment area every day.
3. You **MUST** stop plucking, waxing, or electrolysis for 6 weeks prior to treatment.
4. If have had a history of perioral herpes, prophylactic antiviral therapy may be started the day before treatment and continued one week after treatment.
5. **TAN SKIN CANNOT BE TREATED WITH THE ALEXANDRITE LASER!** If treated, you will have hypopigmentation (white spots) and this may not clear for 6 months or more.
6. The use of tanning cream must be discontinued one week before treatment.
7. On the day of the laser treatment, do not wear any lotions, body oils, perfumes, deodorant, or makeup in the area to be treated.

POST-TREATMENT CARE

1. Immediately after treatment, there should be erythema (redness) and edema (swelling) at the treatment site, which may last up to 2 hours, or longer. The erythema may last up to 2-3 days. The treated area will feel like a sunburn for a few hours after treatment. The application of ice during the first few hours after treatment will reduce the discomfort and swelling that may be experienced.
2. Aloe Vera gel or ice may be used after treatment. Darker pigmented people may have more discomfort than lighter skin people and may require the Aloe Vera gel or ice longer.
3. It is recommended to apply **NEW** makeup only to reduce the possibility of infection if makeup is required immediately after treatment.
4. Avoid sun exposure for 1 to 2 months to reduce the chance of hyperpigmentation or darker pigmentation.
5. Wear broad spectrum sun protection with SPF 30 or higher on any exposed treatment area every day.
6. Do not use any other hair removal treatment products or similar treatments (waxing, electrolysis or tweezing) that will disturb the hair follicle on the treatment area before your next laser treatment is performed. Shaving or depilatories may be used.
7. Call Advanced Skin Fitness with any questions or concerns you may have after the treatment. If you experience any brown crusting, do not pick or scratch. Allow it to fall off naturally. In rare cases you may have areas that develop blisters. Do not pick or remove the scabs. Apply antibiotic cream twice daily until healed. The area will heal in 5 – 7 days.
8. Anywhere from 5-14 days after the treatment, shedding of the surface hair may occur and this appears as new hair growth. This is **NOT** new hair growth. You can clean and remove the hair by washing or scrubbing the area with a wet cloth or loofah sponge.
9. There are no restrictions on bathing except to treat the skin gently, as if you had a sunburn, for the first 24 hours.

For optimum results it is important that you keep all of your appointments. Your follow-up treatment is customized to your individual conditions and your schedule has a direct effect on the final results of your treatments.

Signature: _____ Date: _____

Printed Name: _____

Laser Tech: _____ Date: _____



Credit Card Charge Authorization Agreement

We request the courtesy of a 24 hour notice in the event an appointment needs to be cancelled or rescheduled. A \$75 no show fee for facial treatments and a \$100 no show fee for laser treatments will apply in the event advanced cancellation notice is not given. Appointments booked same day of service will be assessed a no show fee should cancellation become necessary. For treatments that are pre-paid, the pre-paid treatment will be forfeited without 24 hour notice of cancellation. Thank you for your cooperation.

I, _____,

hereby authorize Advanced Skin Fitness to charge my credit card used for my treatments in the amount of \$75 for a missed facial treatment or \$100 for a missed laser treatment.

I have read this entire agreement and understand that I will be held fully responsible for its terms and charges. I agree not to chargeback Advanced Skin Fitness, as long as I receive the services that are entitled to me and guidelines are followed for my rescheduling and cancellation of appointments. Twenty-four hour notice is required for all rescheduling and cancellations.

Name On Card: _____

Signature: _____

Credit Card Billing Address: _____

City, State, Zip: _____

Telephone: (____) _____

Date: ____/____/____