Aesthetic and Anti Aging Medical Center

100 S.Military Trail,Suite 10 Deerfield Beach,FL33442
tel:954 426 9600 fax: 954 426 2257
www.aaamc.net

CONSENT FOR LASER HAIR REMOVAL TREATMENT

Laser Hair Removal

Patient Name: _____ **Date :** _____

I understand that DS is a device used for hair removal and that clinical results may vary in different skin types. I understand there is a possibility of short-term effects such as reddening, mild blistering or scabbing, temporary bruising and temporary discoloration of the skin, as well as the possibility of rare side effects such as scarring and permanent discoloration. These effects have been fully explained to me.

Clinical results may vary depending on individual factors, including medical history, skin type, patient compliance with pre/post treatment instructions, and individual response to treatment. I understand that alternative methods of removing excess hair are shaving, waxing, plucking, coloring and electrolysis.

I understand that treatment by the DS hair removal applicator involves a series of treatments and the fee structure has been fully explained to me.

I certify that I have been fully informed of the nature and purpose of the procedure, expected outcomes and possible complications and I understand that no guarantee can be given as to the final result obtained. 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, and that I have not taken Accutane within the last six months. I do not have a pacemaker or internal defibrillator. I do not have a history of keloid scarring, have not had deep chemical or mechanical peeling with last 2 weeks preceding and do not have poorly controlled diabetes.

I consent to the taking of photographs and authorize their anonymous use for the purposes of medical audit, education and promotion.

I certify that I have been given the opportunity to ask questions and that I have read and fully understand the contents of this consent form.

_____ _____

Patient Signature **Date** **Witness Signature** **Date**

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Patient Name: _____ **Date :** _____

HAIR REMOVAL PRE - TREATMENT INSTRUCTIONS

- **Sun avoidance and sun protection will reduce risk of dyschromia (hyper or hypopigmentation) and epidermal effects. Light to moderately tanned skin can be treated with appropriate parameters. Deeply tanned skin should be treated 4-6 weeks after active sun exposure.**
- **Stop applying medications or irritating agents to the skin for 1-2 days before treatment.**
- **Shave treatment area one day before treatment. For rapidly growing areas, such as men's beard, shave may be done day of treatment.**
- **Skin should be clean, with no lotion, make-up, deodorant, perfume, or sunscreen before treatment.**
- **Wait at least two weeks after chemical peel or injections in treatment area before hair removal treatment.**
- **Wait at least 4-6 weeks before treating is patient waxed, tweezed or plucked in the treatment area.**
- **Wait at lease 2 weeks before treating if patient had collagen injections or other fillers or injectables in treatment area.**

Patient Signature: X _____ **Date:** _____

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HAIR REMOVAL POST - TREATMENT INSTRUCTIONS

- **Avoid sun and apply sunscreen to treated area for few days following treatment. Darker skin types should comply with sun avoidance and sun protection, especially if there is tendency to hyperpigment.**
- **Do no irritating treatment chemically or mechanically to treated area for a couple days after treatment.**
- **Avoid direct and indirect heat to treated areas for a couple days after treatment, especially if patient has tendency to hyperpigment.**
- **Some shedding or extrusion of treated hairs will occur around 2-4 weeks following treatment.**
- **Treated area can be shaved or clipped, but not tweezed, plucked or waxed. Shave treatment area one day prior to next treatment. After third treatment, leave growth unshaved for assessment before fourth treatment.**

Patient Signature: X _____ **Date:** _____

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PATIENT INFORMATION SHEET

Date:_____

Last Name: _____ First Name _____

Date of Birth: _____ Social Security Number _____

Adress_____Apt#_____

City: _____State _____ Zip_____

Phone Numbers Home_____ Cell _____Work_____

Occupation_____email address_____

How did you hear of our services?_____

Reason for Consult_____

_____

Please Complete the Following Medical Questions

Are you seeking treatment for Cosmetic _____or medical purposes?_____

Prior surgeries and dates:_____

Have you ever had cosmetic enhancement including Botox, Dysport, soft tissue filler,

Vein tx, Laser, Photo rejuvenation treatments for any reason? Yes___ No___# times per yr___

Dates & Type of Tx._____

Have you had any side effects or complications from Botox,Dysport or Skin fillers? No__Yes__

If yes explain:_____

Do you, or have you ever had a major Illness?_____

Do you have any acute or chronic skin disease?_____

Do you have a history of cold sores or have you any now?_____

Have you ever experienced any muscle weakness?_____

Are you currently being treated for any physical or mental condition? No____Yes___Pease Explain_____

Are you taking any prescribed medications? No__Yes___List:_____

_____

Allergies_____Reactions_____

Do you smoke? No____Yes____per day x____years x____ Quit____When?_____

Do you drink alcohol? Yes___No___Amount_____Do you use illeagal drugs?Yes___No___

Please list below all prescribed, herbal,or over the counter medications you are presently taking, or have taken within the past 2 weeks:_____

_____

Patient Signature: X_____ **Date:**_____

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Skin Type Assessment

Patient Name: _____ **Date:** _____

Genetic Disposition:

Score	0	1	2	3	4
Eye Color	light blue, green	gray	blue	dark brown	Brown/black
Hair Color	sandy, red	blonde	chesnut/dark blonde	dark brown	black
Skin Color	Reddish	Very pale	Pale	Light brown	Dark brown
Freckles	Many	Several	Few	Incidental	None

Reaction to Sun Exposure:

Score	0	1	2	3	4
Sunburn	Redness/blistering/pees	Blistering/peels	Sometimes peels	Rarely burns	never
Turn Brown	Hardly/not at all	Light tan	Medium tan	Tans easily	Browns quickly
Brown after sun	Never	Seldom	Sometimes	Often	Always
Face reaction	Very sensitive	Sensitive	Normal	very resistant	No problem

Tanning Habits:

Score	0	1	2	3	4
When last exposed	>3 months	2-3 months	1-2 months	< 1 month	< 2 weeks
Treatment Area	Never	Hardly ever	Sometimes	Often	Always

Total: _____

Heritage:

For each parent of African American or East Indian descent add	10
For each grandparent of African-American or east Indian add (if no points for parents)	5
If Asian, Hispanic, East Indian, Mediterranean, Pacific Islander or indigenous to the Americas add	5
For each great –grandparent of African-American descent add (if no points from parents and grandparents)	3

For Office Use only

Summary:

Total for genetic disposition + reaction to sun + Tanning _____
Total for Heritage _____
Skin Type Score (add above 2 lines) **Total** _____

Skin Type Score	Skin Type
0 to 8	**I**
9 to 16	**II**
17 to 24	**III**
25 to 30	**IV**
31 to 34	**V**
35 and over	**VI**