



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? YES NO

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 any other condition or illness.

Please List: _____

2. Do you have **ANY** current or chronic skin conditions? YES NO

Also disclose any history of vitiligo, eczema, melasma, psoriasis, allergic dermatitis, any diseases affecting collagen including Ehlers-Danlos syndrome, scleroderma, skin cancer, or any other skin condition.

Please List: _____

3. Are you currently under a doctor's care? If so, for what reason? YES NO

4. Do you take/use **ANY** medications (prescriptions and nonprescriptions), vitamins, herbal or natural supplements, on a regular or daily basis? YES NO

Please List: _____

5. Are there any topical products (both medical and non-medical) that you use on your skin on a regular or daily basis? YES NO

Please List: _____

6. Do you take/use **ANY** systemic/oral steroids (e.g., prednisone, dexamethasone)? YES NO

7. Do you have **ANY** allergies to medications, foods, latex or other substances? YES NO

Please List: _____

8. (For women) are you or could you be pregnant? YES NO

9. (For women) are menstrual periods irregular, or have you ever been diagnosed with Polycystic Ovarian Disorder? YES NO

10. Do you have a history of herpes I or II in the area to be treated? YES NO

11. Do you have a history of keloid scarring or hypertrophic scar formation? YES NO

12. Do you have a history of light induced seizures? YES NO

13. Do you have any open sores or lesions? YES NO

14. Do you have any history of radiation therapy in the area to be treated? YES NO

MEDICAL HISTORY, CONTINUED

YES NO

15. 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? YES NO
Please List product name and date last used: _____
16. In the last three (3) months, have you used any of the following products:
glycolic acid or other alphahydroxy or betahydroxy acid products;
exfoliating or resurfacing products or treatments? YES NO
Please List product name and date last used: _____
17. 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: _____ YES NO
18. 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: _____ YES NO
19. Have you taken Accutane® (or products containing isotretinoin) in the last 12 months? YES NO
20. Have you taken Tretinoin (like Retin-A, Renova) in the last 6 months? YES NO
21. 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? YES NO
22. Do you have a pacemaker? YES NO

Please include your email address to receive appointment confirmations, and monthly information on
special pricing and/or special events:

_____ @ _____

How did you hear about us? _____

Signature: _____ Date: _____

I request and authorize Dr. _____ to perform a procedure on me known as: _____ using the SmartSkin CO₂ laser.

The nature and effects of the procedure, the risks, ramifications, complications involved, as well as alternative methods of treatment have been fully explained to me by the physician or designated person and I understand them.

I have been thoroughly and completely advised regarding the objectives of the procedure. I understand that the practice of medicine and surgery is not an exact science and no results have been guaranteed. I acknowledge that imperfections might result and that the operative result may not reach my expectations. I certify that no guarantees have been made by anyone regarding the procedure(s) that I have requested and authorized. I understand that in the unlikely case where an imperfection results, the patient and doctor may determine the necessity of a secondary procedure and such revisions are not included in the initial surgical facility or anesthesia fee, but they will be billed at a lesser rate.

I understand that I may be required to wear the garment continuously for the number of days determined by the surgeon(s); removal is only permitted to wash and apply sterile dressing to the treatment area or take a shower.

I understand that possible adverse effects may include bleeding, infection, scarring, skin contour irregularities, asymmetry, surgical shock, pulmonary complications, skin loss, seroma, allergic reactions, and anesthesia related complications. These may occur and have been discussed and understood. I understand the importance of pretreatment and posttreatment instructions and that the failure to comply with these instructions may increase the possibility of complications.

I recognize that during the course of the operation unforeseen conditions may necessitate additional or different procedures other than those above. I therefore further authorize and request that the above named surgeon(s) perform the procedures that are, in his professional judgment, necessary and desirable.

I understand that local and/or tumescent anesthesia is normally required when liposuction is performed. I consent.

Photographs will be taken of the region of treatment. I give permission for these photographs to be used for the purposes of professional publications, training, educational, or sales purposes. If I do not agree to being photographed, it will in no way affect my present or future care. I agree to have photographs taken as a part of this study as described in this form Yes No.

I certify that I have read the above authorization, that the explanations referred to therein were made to my satisfaction, and that I fully understand such explanations and the above authorization.

Signed: _____ Date: _____

(Patient or person authorized to consent for the patient)

Witness: _____ Date: _____



Skin Typing

One of the parameters for the success of your laser treatment is the correct typing of your skin.

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 IV). The two main factors that influence skin type are genetic disposition and reaction to sun exposure and tanning habits. Skin type is determined genetically along with the color of your hair and eyes. The way your skin reacts to sun exposure is the second component in assessing your skin type. Finally, your tanning habits and exposure to the sun (past and future) are very important in the proper evaluation of your skin type.

Please take a moment to complete this essential questionnaire:

Score <i>(please circle)</i>	0	1	2	3	4
What is your eye color?	light blue, gray, green	blue, gray or green	blue	dark brown	brownish black, hazel
What is your natural hair color?	sandy red	blonde	chestnut or dark blonde	dark brown	black
What is your skin color? (non-exposed areas)	reddish	very pale	pale with beige tint	light brown	dark brown
Do you have freckles?	many	several	few	incidental	none
			Genetic Disposition	SCORE:	
Score <i>(please circle)</i>	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	rare burns	never had burns
To what degree to you turn brown?	hardly or not at all	light color tan	reasonable tan	tan very easily	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
			Reaction to sun exposure	SCORE:	
Score <i>(please circle)</i>	0	1	2	3	4
When did you last tan?	more than three months ago	2 to 3 months ago	1 to 2 months ago	less than 1 month ago	less than 2 weeks ago
Did you expose the area to be treated to the sun?	never	hardly ever	sometimes	often	always
			Tanning Habits	SCORE:	

Summary		Skin Type Score	Fitzpatrick Skin Type
Total score for:		0 to 7	I
Genetic disposition	+	8 to 16	II
Reaction to sun exposure	+	17 to 25	III
Tanning habits	+	26 to 30	IV
Skin Type Score:	=	Over 30	V- VI

Patient Name: _____ Date: _____