



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: _____
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: _____
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: _____



CONSENT FOR LASER/LIGHT BASED TREATMENT.

I authorize Ocean Med Spa 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 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, and reducing or eliminating hair. I understand 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 chromosphere 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 lights is sometimes uncomfortable and may feel like a moderate to severe pinprick or flash of heat. 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 a few hours to four days or longer. Cooling the area after the treatment (for example, ice pack or topical gels) may help reduce discomfort and swelling.

Common side effects include temporary redness (erythema) or a mild "sunburn"- like effect that may last a few hours to 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 results.

Pigment changes, including hypopigmentation (lightening of the skin) or hyperpigmentation (darkening of the skin), lasting one to six (1-6) months or longer. Occasionally, the pigment changes are permanent. 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 (white discoloration of skin) and significant redness.

With ablative laser treatments, there are additional risks of discomfort, focal areas of bleeding bruising, poor healing, serous discharge, and infection. 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.

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 (SPF45 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. Occasionally, there may be more regrowth than before.

I should call Ocean Med Spa 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 needed.

Signature	Date
Print name	
Witness signature	Date
Print Name	



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: _____