

### 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: \_\_\_\_\_

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

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

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

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

#### WHEN YOU SUNBATHE, HOW DOES YOUR SKIN RESPOND?

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> ALWAYS BURN, NEVER TAN             | <input type="checkbox"/> USUALLY BURN, TAN WITH DIFFICULTY | <input type="checkbox"/> SOMETIMES BURN, TAN ABOUT AVERAGE |
| <input type="checkbox"/> ALMOST NEVER BURN, TAN VERY EASILY | <input type="checkbox"/> RARELY BURN, TAN EASILY           | <input type="checkbox"/> 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
GENITAL 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**

<b>Score</b>	<b>0</b>	<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>
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:**

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

**NAME:** \_\_\_\_\_ **DATE:** \_\_\_\_\_

**COMMENTS:** \_\_\_\_\_

\_\_\_\_\_



Patient Consent for Photorejuvenation

**Patient Name:** \_\_\_\_\_

Procedure: Photorejuvenation

I hereby authorize and direct any associates or assistants of Advanced Skin Fitness to perform photorejuvenation on me. **Multiple treatments** will be required to achieve cosmetically acceptable results. I understand that some of a man's beard will be removed during photorejuvenation. 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)

\_\_\_\_\_ The potential benefits of photorejuvenation.

\_\_\_\_\_ The most likely possible complications or risks involved with photorejuvenation include, but are not limited to blistering with infection and scarring, scabbing, bruising, and long-term pigmentary changes (hypopigmentation or hyperpigmentation.)

\_\_\_\_\_ 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 PhotoFacial for brown spots and broken capillaries.** I understand that it is my responsibility to let my technician know if I have received any tan throughout the course of my treatment.

\_\_\_\_\_ 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.

\_\_\_\_\_ Topical anesthetic creams will lessen the discomfort in sensitive areas.

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

\_\_\_\_\_ I hereby authorize Advanced Skin Fitness or any associates to take pictures of the treated area to be used in my patient file and/or teaching purposes. I understand that the release of this information will be kept confidential and that no patient names will be used.

\_\_\_\_\_ I understand that immediately following the laser treatment, the treated area will appear as a red discoloration and have edema (swelling) followed by scabbing of the sun damaged areas. The redness (erythema) and discoloration may take up to 3 - 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 care documents. Compliance with recommended 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 photo rejuvenation 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. If have had a history of perioral herpes, prophylactic antiviral therapy may be started the day before treatment and continued one week after treatment.
4. **TAN SKIN CANNOT BE TREATED WITH THE PHOTOFACIAL DEVICE!** If treated, you will have BURNS with hyperpigmentation and this may not clear for 6 months or more.
5. The use of tanning cream must be discontinued one week before treatment.
6. 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 days, or longer. 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.
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 hair removal treatment products or similar treatments (waxing, electrolysis or tweezing) This can cause hyperpigmentation. Shaving 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. **IF THIS HAPPENS CALL THE OFFICE IMMEDIATELY.** Do not pick or remove the scabs. Apply antibiotic cream twice daily until healed. The area will heal in 5 – 7 days.
8. There are no restrictions on bathing except to treat the skin gently, as if you had a sunburn, for the first 24 hours. Use no retin-a products, salicylic acid, or other AHA's such as glycolic or lactic for 1 week after treatment.

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: \_\_\_\_/\_\_\_\_/\_\_\_\_