



I authorize Allen Aesthetics and laser Center and its designated staff to perform Laser Hair Removal, IPL Fotofacial, Skin Tightening, Microdermabrasion, Pixel, Tattoo Removal and/or Vein Therapy on my body. I understand that these services are FDA-approved. The possible adverse reactions which are as follows:

PAIN:

The laser causes mild discomfort, which can be minimized by applying an anesthetic cream approximately one hour before each treatment.

BLISTERING:

Burning may occur in skin that is tan. Although rare, blistering is possible as is hypo- or hyper-pigmentation (lightened or darkened areas of skin).

CRUSTING:

If superficial crusts form, they should resolve with the gentle care as described in the aftercare instructions.

PIGMENT CHANGES:

Temporary color changes such as hyperpigmentation, which is a brown discoloration, or hypopigmentation, which is a skin lightening, may occur. While these can take 3 to 6 months to resolve, they rarely lead to permanent scarring (under 1%).

EYE PROTECTION:

Protective eyewear must be worn by everyone present during treatments.

PERSISTENCE OF HAIR:

Evaluation of Laser Hair Removal is on-going, but studies and clinical experience suggest that multiple treatments produce long-term hair loss. Although some clients will respond better than others, most clients will experience progressive hair loss with each treatment.

By signing below, I acknowledge that I have read the adverse reactions above and I feel that I have been adequately informed of the risks of my treatment. Before each treatment I will inform the laser technician if I have taken any new medications since my last treatment or if I have tanned the areas to be treated either by sunlight or artificially. I understand that some medications can make my skin photosensitive and either of the aforementioned conditions could cause the laser to damage my skin. I also agree to comply with the recommended aftercare guidelines which are crucial for healing, prevention of scarring and hyperpigmentation. I understand that I will need 8 treatments for hair removal. I hereby release Allen Aesthetics and Laser Center, its medical staff and the specific technician from liability associated with the above.

Client signature

Date



Medical History

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Date of Birth: _____ Circle one: Male or Female

Home Phone: _____ Cell Phone: _____

Occupation: _____ Employer: _____

Pharmacy name/location/number: _____

How did you hear about us? _____

Reason for today's visit: _____

Do you have any particular skin problem or concerns? _____

Do you have any known allergies? _____

Please list any medications, including prescription and/or over-the-counter medicines you are presently taking (oral and topical): _____

Please list any past/present medical conditions or surgeries: _____

List previous types of hair removal/ laser procedures used for the area(s) you want treated (e.g. waxing, electrolysis, shaving, depilatories, laser, photofacial, vein, hair removal, acne, rosacea, hyperpigmentation): _____

When: _____

List previous types of cosmetic procedures (chemical peel, microdermabrasion, botox, collagen injections, sclerotherapy, micropigmentation-permanent-make-up, etc.):

_____ When: _____



Circle Yes or No:

- Yes No 1.) Do you have cold sores? If yes, when was the last? _____
- Yes No 2.) Do you have HIV?
- Yes No 3.) Do you have keloid formation or scars that haven't healed smoothly?
- Yes No 4.) Do you have any skin disorders e.g. psoriasis, vitiligo, skin cancer, etc.?
Please list _____
- Yes No 5.) Are you diabetic?
- Yes No 6.) Do you have hepatitis?
- Yes No 7.) Are you or could you be pregnant?
- Yes No 8.) Do you have any endocrine disorders?
- Yes No 9.) Do you have polycystic ovarian disease?
- Yes No 10.) Do you have heart disease?
- Yes No 11.) Do you have lung disease?
- Yes No 12.) Do you have high blood pressure?
- Yes No 13.) Do you take any medication that causes photosensitivity?
- Yes No 14.) Do you have any clotting problems?
- Yes No 15.) Have you ever had a DVT (deep venous thrombosis)?
- Yes No 16.) Do you have a tattoo(s) in the area(s) that you want treated?
- Yes No 17.) Have you sunbathed or been in a tanning bed within the last 30 days?
- Yes No 18.) Have you taken Retin A or Retinol products in the last 2 weeks?
- Yes No 19.) Have you taken Accutane in the past year?
- Yes No 20.) Do you have excessive hair growth? If yes, in what areas on the body?

- Yes No 21.) Have you a hypo/hyperactive thyroid condition?
- Yes No 22.) If yes, have you had surgery or take medicine for the condition?
- Yes No 23.) Do you have Hepatitis (type_____) or Herpes I/II?
- Yes No 24.) Do you have a heart condition or pacemaker?

Describe your skin. Check those that apply:

Oily____Dry____Combination____Normal____Sensitive____Sun-Damaged____
 Freckled____Mature____Wrinkled____Broken Surface Capillaries____
 Hypo/HyperPigmented____Melasma____Rosacea____Eczema____
 Psoriasis____Acne____Scarred____Large Pores____Small pores____

Please list your parent's ethnic background: _____

What is your e-mail address? _____

To the best of my knowledge, the information I provided is true. I understand that this information is confidential and will not be disclosed without my written consent.

Patient or Legal Guardian Signature: _____ Date: _____



Fitzpatrick Skin Typing

This form is to give us a general idea of your skin type. Please answer to the best of your knowledge.

We do not recommend laser therapy if any of the conditions below exist. Please check any box that describes your current health condition. Please advise the technician of any medications you are taking (see form).

- _____ Pregnancy
- _____ Photosensitivity Disorders
- _____ Herpes (active)
- _____ Shingles (active)
- _____ Seizure disorders triggered by light

Please circle the choices that best describe you and your skin.

	0	1	2	3	4	Scores
What is your eye color?	Light Blue	Blue, Gray or Green	Blue / Hazel	Brown	Brownish-Black	
What is the natural color of your hair?	Sandy, Red	Blonde	Dark Blonde / Light Brown	Chestnut / Brown	Black	
What is the 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	
What happens when you stay too long in the sun? (1 st exposure)	Painful, redness, blistering, peeling	Blistering, followed by peeling	Burns-sometimes followed by peeling	Rarely burns	Never burns	
To what degree do you turn brown?	Hardly or not at all	Light color tan	Reasonable tan	Tan very easy	Turn dark brown quickly	
Do you turn brown after several hours of 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	

When did you last expose your body to sun or tanning booth or tan cream?	More than 3 months ago	2 – 3 months ago	1 – 2 months ago	Less than 1 month ago	Less than 2 weeks ago	
When did you last expose the area to be treated to sun?	More than 3 months ago	2 – 3 months ago	1 – 2 months ago	Less than 1 month ago	Less than 2 weeks ago	

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

TOTAL / SKIN TYPE: _____

Client Signature

Date

- Skin Type I Never tans, always burns (extremely fair skin, blonde/red hair).
- Skin Type II Occasionally tans, usually burns (fair skin, sandy to brown hair, green/brown eyes).
- Skin Type III Often tans, sometimes burns during first exposure to sun (medium skin, brown hair).
- Skin Type IV Always tans, never burns (olive skin, brown/black hair).
- Skin Type V Never burns (dark brown skin, black hair).
- Skin Type VI Never burns (black skin, black hair).