Repeat Laser Hair Reduction Questionnaire

In order to ensure that there have been no changes and in order for us to offer you the best and safest treatment, we would be grateful if you would fill in the following questionnaire.

1. Did you have any problems following your last laser hair reducing treatment? YES NO

   If so, what were they?

2. Are you currently taking any medication or have you done so since your last treatment (this includes herbal remedies, particularly St Johns Wort)? YES NO

   If so, what were they?

3. Have you sunbathed, used sun beds or developed a tan darker than your usual skin colour (even from walking around, driving or sitting in the sun) in the last 6 weeks? YES NO

4. Have you used self tanning products in the last 3 weeks? YES NO

5. Have you used glycolic acid or chemical peels or retinoid / retinol (vitamin A) creams on the area to be treated in the last two weeks? YES NO

6. Have you applied gels, oils, deodorants or perfumed products to the area to be lasered in the last 12 hours? YES NO

7. Are you pregnant or breast feeding? YES NO

8. Have you developed any allergies? (e.g. to latex, local anaesthetic or any cosmetic products) YES NO

I consent to Laser Hair Reduction to be repeated today. I have reported any adverse effects from the previous treatment and have not recently or currently taken any new medication (including herbal remedies, particularly St John's Wort) different from those taken at the previous session. I have not had any recent sun exposure and do not have a tan. I have read and understood the consent form on "Laser Hair Reduction".

Date

(Patient's Signature)

Date

(Healthcare Professional's Signature)

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Elite Hair Removal Consultation

Name Age Sex Birth Date

Address

Skin Type (I-VI) Fair Olive Dark (Asian/Hispanic) Black

Hair Type: Coarse Fine Comments:

Hair Color: Black Brown Red Blonde Gray Other

Allergies:

Present Medications (Accutane, Aspirin, Antivirals, Coumadin, Photosensitivity drugs such as St. John's Wort):

Present Illnesses:

History of keloids/hypertrophic scars:

Other: (tanning history):

Area to be Treated:

Previous Treatment: (specify date/number of treatments/frequency/tissue response)

Wax epilation Mechanical epilation (plucking) Electrolysis Bleaching

Frequency of tweezing area:

Previous laser treatment:

Other type treatment:

Recommendations:

- Discuss treatment options (testing, color hair responds best, number of treatments).
- Discuss client expectations: (understand need for multiple treatments, after care, possible side effects, etc).
- Discuss physician consultation before or after test for a treatment recommendation.
- Review in detail full treatment schedule process (waiting period in-between treatments, when to expect regrowth, shaving ONLY 6 weeks before/after treatment).
- Discuss possible side effects (hyperpigmentation, hypopigmentation, purpura, scaring) and length of time to expect healing if side effects occur.
- Discuss specifics of area to be treated (test small area for tissue response BEFORE full treatment, not eat gas causing foods if treating anal area, protect eyes/eyebrow, nose, ears when treating here). Other:
- Discuss importance of sun exposure avoidance and the use of sunscreen during the entire treatment program.
- Discuss sensation of the laser/cooling and the option for topical anesthesia if requested.
- Discuss benefits of laser treatment (possible long-term hair removal), laser safety required.
- Discuss cost of treatment (payment schedule, cost of multiple treatments versus single payment per visit).

Comments:

I agree that the information listed above has been reviewed and presented with my clear understanding of what this procedure involves. All of my questions have been addressed to my satisfaction.

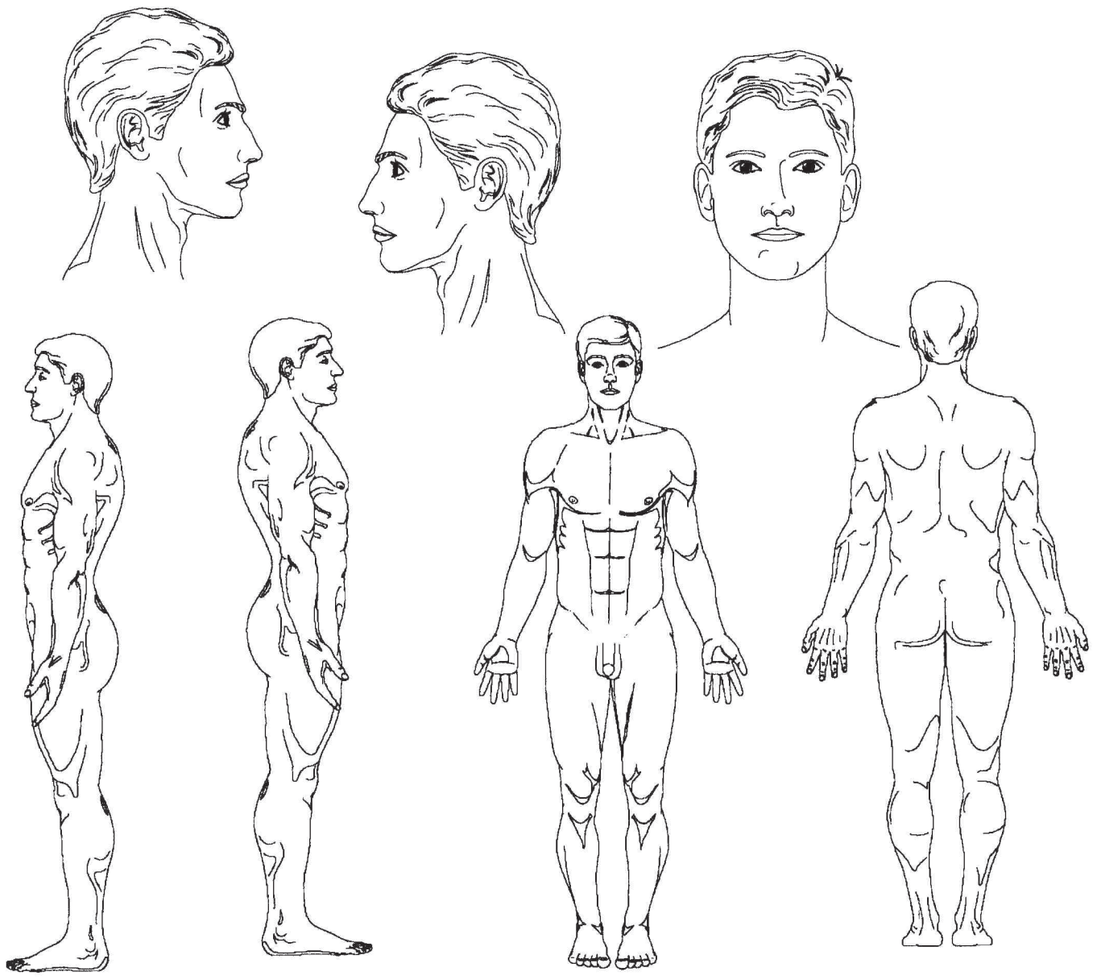
Signed: Date:

Elite Treatment Record

Date: Treatment # or Test Patch:
Patient Name: Birth Date:
Address:

Laser Practitioner:
Vascular / Pigmented Lesion Diagnosis or Colour of Hair:
Fitzpatrick Skin Type: 1 2 3 4 5 6
Comments:

Area Treated	Wave Length (mm)	Pulse Width (msec)	Spot Size (mm)	Energy (J/ cm2)	Rep Rate (Hz)	#TX Pulses	Cooling Level



Patient Medical History

Today's Date: Date of Birth: Age: Sex: M F
Full Name:
Home Address:

Home Phone: Work Phone: Occupation:
GP: GPAddress:
Emergency Contact: Relationship: Phone Number:

Please answer these questions and then complete the questionnaire on the back of this form
Have you ever been treated here before: NO YES
If yes, for what reason(s)?
Do you have any serious health conditions: NO YES
Have you suffered from epileptic fits? NO YES
Do you have any allergies? NO YES
If yes, please list:

When you go into the sun without a tan, do you:

Always burn, then tan Usually burn, sometimes tan Sometimes burn, usually tan Never burn, always tan

Do you have sensitive skin? NO YES

Have you ever had a skin problem or been under the care of a dermatologist? If yes, please describe (include dates under care):

Do you have any implants, tattoos or permanent makeup in / on the area to be treated NO YES
Location?

Have you ever had X-ray treatment or radiation therapy to your skin? NO YES If yes, date diagnosed / treated:

Have you ever had Photodynamic Therapy (PDT)? NO YES If yes, date diagnosed / treated:

Present Medications
Do you take any medications, drugs, or over the counter preparations / remedies?
(e.g. Roaccutane, Isotretinoin or other retinoids, St John's Wort, Amiodarone, Minocycline, Minocin,

Dianette or other contraceptive pill, any steroids, Warfarin or other blood thinners, any iron supplements)
(Please list any medications or herbal remedies and where possible, date started, how many milligrams, how many times a day)

Have you ever used or had Renova or Retin A, Alpha hydroxyl, Glycolic Acid or other cosmetic peels? NO YES

Have you ever had Botox or fillers? NO YES

Prior hospitalizations and surgery in the last 5 years (Please give approximate dates)