Graper • Harper
Cosmetic Surgery

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Consultation Form

In order to provide you with the most appropriate laser hair removal treatment, we would appreciate your time in completing the following questionnaire. All information is strictly confidential.

1. Personal History

Date: _____

Full Name: _____

Date of Birth: _____ Age: _____ Sex: □ M □ F

Home Address: _____

City:_____ State: _____ Zip Code: _____

Home Phone: _____ Cell Phone:_____ Work Phone:_____

Email: _____

Occupation:_____

Emergency Contact: _____ Relationship: _____ Phone Number: _____

2. Medical History

Do you have any of the following medical conditions? (Please check all that apply)

□ NONE	□ Cancer	□ Diabetes
□ High Blood pressure	□ Bleeding disorders	□ Arthritis
□ Frequent cold sores	□ HIV/AIDS	□ Keloid scarring
□ Skin disease/Skin lesion	□ Seizure disorder (epilepsy)	□ Hepatitis
□ Hormone imbalance	□ Thyroid imbalance	□ Herpes
□ Any active infection		

Do you have any other health problems or medical conditions? NO YES

If yes, please list: _____

Have you ever had a skin problem or been under the care of a dermatologist? NO YES

If yes, please describe (include dates under care): _____

Do you have any allergies? NO YES

If yes, please list: _____

Are you pregnant or breast feeding? NO YES

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Present medication:

Do you take any medications, drugs, or over the counter preparations/remedies? (e.g. Roaccutane/Accutane Isotretinoin or other retinoids, Amiodarone, Minocycline, Minocin, Dianette or other contraceptive pill, any steroids, Warfarin or other blood thinners, any iron supplements, other…).

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 Retin A, Alpha hydroxyl, Glycolic Acid or other cosmetic peels? NO YES

Have you ever had Botox or fillers? NO YES

Do you have sensitive skin? NO YES

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:_____

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

_____

_____

3. Skin Type Evaluation

Genetic Disposition:

Score	0	1	2	3	4
Your natural eye color	Light blue, green, grey	Blue, green, grey	Light brown	Dark brown	Brownish/ black
Your natural hair color	Sandy, red	Blonde	Chestnut/Dark brown	Dark brown	Black
Color of unexposed skin	Reddish	Very pale	Pale with beige tint	Light brown	Dark brown
Do you have freckles?	Many	Several	Few	Incidental	None

Total score for genetic disposition: _____

Reaction to Sun Exposure:

Score	0	1	2	3	4
What happens if you stay in sun too long?	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 easily	Turn dark brown easily
Do you turn brown several hours after exposure to sun?	Never	Seldom	Sometimes	Often	Always
How does your face react to sun?	Very sensitive	Sensitive	Normal	Very resistant	Never had a problem

Total score for reaction to sun exposure: _____

Tanning Habits:

Score	0	1	2	3	4
When did you last expose your body to sun or tanning booth?	More than 3 months ago	2-3 months ago	1-2 months ago	Less than 1 month ago	Less than 2 weeks ago
Have you exposed the area to be treated to sun or tanning booth?	Never	Hardly ever	Sometimes	Often	Always

Total score for tanning habits: _____

Summary - Total Scores:

	Score
Genetic Disposition Score:	
Reaction to Sun Exposure Score:	
Tanning Habits Score:	
TOTAL SKIN TYPE SCORE:	

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

Patient's Fitzpatrick Skin Type: _____

Comments_____

_____

_____

4. Pre-Treatment Information/Instructions

It is important that the area being treated *not be exposed to the sun* at least 6 weeks before the treatment. A broad-spectrum (UVA/UVB) sunscreen of 50 SPF or higher should be applied whenever area to be treated is exposed to the sun. This practice should continue between treatments and following your last treatment for at least 6 weeks. This can prevent post treatment complications such as hyper-pigmentation, or hypo-pigmentation.

- DO NOT use self-tanning products for at least 4 weeks prior to laser treatment.
- DO NOT use Retin-A or Renova one week prior to laser treatment.
- DO NOT take Accutane for at least 2 months prior to laser treatment.
- DO NOT take Aspirin for several days before treatment in order to avoid purpura / bruising.
- DO NOT carry out other hair removal treatments (waxing, tweezers, electric epilators) or bleaching hair for at least 1 month before the first treatment. Regular shaving is fine.
- The area should be shaved 24-48 hours prior to treatment. If hair is fine and no shadow can be seen after shaving, it is a good idea to take a photo of unshaven area to show technician.
- DO NOT wear *make-up*, *deodorant*, *perfumes* or *powder* on the areas to be treated.
- Plan to avoid tight elastic at the leg opening following bikini treatments.
- If you have a history of oral herpes (fever blisters / sores) and are having your mouth area treated, you will need to have your physician prescribe suppressive therapy and take as directed.

5. 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.

- Did you have any problems following your last laser hair reducing treatment? NO YES
- If so, what were they? _____
- Have you started taking any medications, drugs or over-the-counter preparations/remedies since your last treatment? NO YES
- If so, what were they? _____
- Have you sunbathed, used sun beds or developed a tan darker than your usual skin color (even from walking around, driving or sitting in the sun) since your last treatment or in the last 6weeks? NO YES
- Have you used self-tanning products since your last treatment or in the last 4 weeks? NO YES
- Have you used glycolic acid or chemical peels or retinoid/retinol (vitamin A) creams on the area to be treated since your last treatment? NO YES
- Have you applied gels, oils, deodorants or perfumed products to the area to be lasered in the last 12 hours? YES NO
- Are you pregnant or breast feeding? YES NO
- Have you developed any allergies since your last treatment? (e.g. to latex, local anesthetic or any cosmetic products) YES NO

Please, report any adverse effects from your previous treatment and any new medications, drugs or over-the-counter preparations/remedies different from those taken at your previous session.

6. Treatment Record – Hair Removal

Patient Name or Patient ID: Date of Birth: _____ Age: _____ Sex: □ M □ F

Today's Date: _____ Treatment #: _____ or Test Patch: _____

Area to be treated:_____

Skin Type (I-VI): _____ (skin type evaluation at paragraph # 3 above)

Hair Type: □ Coarse □ Thin Comments: _____

Hair Color: □ Black □ Brown □ Red □ Blonde □ Grey □ Other _____

Laser Practitioner: _____

USING MOVEO HANDPIECE:

Area	Wavelength (nm)	Fluence (J/cm^2)	Ton (Soft/ Normal/High)	Frequency (Hz)	Total energy per 100 cm^2 (J)	Spot Size

USING STANDARD HANDPIECE:

Area	Wavelength (nm)	Spot Size (mm)	Fluence (J/cm^2)	Nr. of pulses	Frequency (Hz)	Ton (ms)	Delay (ms)	Spot Size

Comments: _____

_____

_____

7. Post-Treatment Information/Instructions

Typical immediate post treatment reactions can be: Perifollicular erythema (Slight red bumps which disappear after 1-2 days); Slight edema (minor swelling which disappears after 24 hours); Slight erythema (redness which disappears after 1-3 days).

Post Treatment Precautions

- Treat the area delicately. DO NOT rub, scratch or pick the treated area.
- If the treated area becomes tender or shows signs of infection such as pus, tenderness, or if you develop a fever, contact the technician who performed the treatment at _____ (phone number).
- Avoid using hot water on the treated area for 24 hours following treatment.
- Avoid swimming, sports, and strenuous exercise for 48-36 hours following treatment.
- Do not shave the area if crusting or blistering occurs.
- Do not use hot water on treated areas immediately following treatments.

Care of the Treated Area

- After the laser treatment it is recommended to moisturise and hydrate the skin by applying a lenitive product. Keep the treated area clean.
- Discomfort, such as swelling or redness can be relieved applying a non-cortisone anti-inflammatory cream, preferably with a zinc oxide base, without massaging, or by applying ice. Reapply several times a day for the next few days.
- It is best not to use make-up for three days on the treated area. If make-up is a must, you should apply and remove it very delicately. Excessive rubbing can cause trauma to the area and may increase the chance of scarring or hyper-pigmentation.
- Treated hair will exfoliate or push out in approximately 2 to 3 weeks (sometimes sooner), and may appear darker and thicker before falling out.
- DO NOT shave for a minimum of 3 days post treatment.
- DO NOT occlude the underarm with deodorant for three days. Use a light powder instead.
- When showering, always gently rinse with cool or tepid water and gently pat the area dry. *DO NOT rub*.
- Apply a high-protection sunscreen to the area for 4-6 weeks after treatment. Avoid exposure to direct sunlight or sunlamp.

Remember: To achieve the desired results the specified number of treatments must be adhered to. Skipping treatments, even when it appears you have achieved the results, will result in a less that adequate outcome and long term results will be sacrificed.

To reduce your risk of complications, it is important to follow both PRE and POST treatment instructions. If you have any questions or concerns, please contact your laser technician.

8. Acknowledgement

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.

I acknowledge that I have received a copy of the Pre-Treatment Instructions.

I acknowledge that I have received a copy of the Post-Treatment Instructions.

I understand and acknowledge that payments for the above-named procedure(s) are nonrefundable.

By my signature below, I certify that I have read and fully understand the contents of this permit for Laser Hair Removal and that the disclosures referred to herein were made to me.

Patient Signature _____ Date _____

Doctor Signature _____ Date _____