Juliet
Laser Treatment For Vaginal Health

AESTHETIC

HEALTH HISTORY

PERSONAL INFORMATION

DATE: _____

LAST NAME: _____ FIRST: _____ M.I.: _____

STREET ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

HOME PHONE: _____ WORK PHONE: _____

CELL: _____ EMAIL: _____

DATE OF BIRTH (MONTH/DAY/YEAR): _____ AGE: _____ SEX: ☐ FEMALE ☐ MALE

WHERE DID YOU HEAR ABOUT US: (Please be specific)

INTERNET: _____ REFERRAL : _____

ADVERTISEMENT: _____ IF SO WHERE _____ OTHER _____

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

☐ BOTOX	☐ SUN DAMAGE	☐ SKIN CARE ADVICE / PRODUCTS
☐ FILLERS	☐ CELLULITE REDUCTION	☐ MICRODERMABRASION
☐ ROSACEA	☐ SKIN TIGHTENING	☐ FACIAL/LEG VEIN TREATMENTS
☐ ACNE TREATMENTS	☐ FAT REDUCTION	☐ HAIR REMOVAL
☐ FINE LINES/WRINKLES	☐ TATTOO REMOVAL	☐ VAGINAL REJUVENATION

☐ OTHER, PLEASE SPECIFY _____

DO YOU USE SUNSCREEN? ☐ YES, IF YES SPF # _____ ☐ NO

WHEN YOU SUNBATHE, HOW DOES YOUR SKIN RESPOND?

☐ ALWAYS BURN, NEVER TAN ☐ USUALLY BURN, TAN WITH DIFFICULTY ☐ SOMETIMES BURN, TAN ABOUT AVERAGE

☐ ALMOST NEVER BURN, TAN VERY EASILY ☐ RARELY BURN, TAN EASILY ☐ NEVER BURN, ALWAYS TAN

MEDICAL HISTORY (Check appropriate box next to any condition for which you have ever been treated)

- ☐ ACNE
- ☐ ARTHRITIS
- ☐ AUTOIMMUNE DISORDER
- ☐ BLOOD DISORDERS
- ☐ CANCER (OR RADIATION THERAPY)
- ☐ DIABETES / DIABETIC NEUROPATHY
- ☐ HERPES (OR COLD SORES)
- ☐ HIRSUTISM
- ☐ VITILIGO
- ☐ KIDNEY DISEASE
- ☐ MELANOMA
- ☐ PORT WINE STAIN
- ☐ PSORIASIS
- ☐ PACEMAKER
- ☐ SHINGLES
- ☐ SKIN PIGMENTATION
- ☐ STEROID OR HORMONAL THERAPY
- ☐ HORMONAL IMBALANCES
- ☐ POLYCYSTIC OVARIAN SYNDROME
- ☐ KELOID SCARS / OTHER SCARS

ADDITIONAL QUESTIONS:

1 ARE YOU CURRENTLY BEING TREATED FOR ANY CONDITIONS NOT LISTED? IF YES, PLEASE SPECIFY.

_____

2 ARE YOU CURRENTLY TAKING ANY MEDICATIONS, INCLUDING HERBAL PREPARATIONS, MEDICAL PATCHES OR ASA? IF YES, PLEASE SPECIFY.

_____

3 DO YOU HAVE ANY ALLERGIES? IF YES, PLEASE SPECIFY.

_____

4 HAVE YOU EVER USED (OR ARE CURRENTLY USING) RETIN A OR GLYCOLIC ACID? IF YES, PLEASE SPECIFY.

_____

5 HAVE YOU EVER USED (OR ARE CURRENTLY USING) ACCUTANE? IF YES, PLEASE SPECIFY.

_____

6 HAVE YOU EVER HAD A CHEMICAL PEEL? IF YES, PLEASE SPECIFY.

_____

7 HAVE YOU HAD ANY LASER TREATMENTS? 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? IF YES, PLEASE SPECIFY.

_____

10 DO YOU HAVE ANY TATTOOS OR PERMANENT MAKEUP IN THE AREA TO BE TREATED? IF YES, PLEASE SPECIFY.

_____

11 DO YOU HAVE A PACEMAKER?

_____

12 HAVE YOU EVER BEEN TREATED BY AN ENDOCRINOLOGIST (HORMONE IMBALANCE)?
IF YES, PLEASE SPECIFY.

_____

13 DO YOU SUNBATHE OR USE SELF TANNING LOTIONS OR USE TANNING BEDS? IF SO, THEN HOW OFTEN?

_____

14 HAVE YOU EVER HAD GOLD THERAPY (USED FOR RHEUMATOID ARTHRITIS)

_____

15 ARE YOU CURRENTLY PREGNANT?

_____

16 HAVE YOU HAD FILLER OR BOTOX/DYSPORT INJECTIONS IN THE AREA TO BE TREATED?
IF YES, PLEASE SPECIFY.

_____

17 DO YOU HAVE ANY PARTICULAR SKIN SENSITIVITIES?

_____

PLEASE SIGN BELOW TO INDICATE ALL THE INFORMATION ON THIS FORM IS ACCURATE AND COMPLETE.

SIGNATURE: _____ DATE: _____

CUTERA®
FACE + BODY AESTHETIC SOLUTIONS

Juliet™
Laser Treatment For Vaginal Health

SKIN TYPE CLASSIFICATION QUESTIONNAIRE

SCORE		0	1	2	3	4
	What is the natural color of your hair?	Sandy red	Blond	Chestnut, dark blond	Dark brown	Black
	What is the eye color?	Light blue, Gray, Green	Blue, Gray, Green	Brown	Dark Brown	Brownish Black
	What is the color of sun unexposed skin areas?	Reddish	Very pale	Pale with beige tint	Light brown	Dark brown
	How many freckles on unexposed skin areas?	Many	Several	Few	Incidental	None
	What happens when you are in the sun TOO long without sunblock?	Painful redness, blistering, peeling	Blistering followed by peeling	Burns, sometimes followed by peeling	Rarely burns	Never had a problem
	How well do you turn brown?	Hardly or not at all	Light color tan	Reasonable tan	Tan very easily	Turn dark very quickly
	Do you turn brown within one day of sun exposure?	Never	Seldom	Sometimes	Often	Always
	How does your face respond to the sun?	Very sensitive	Sensitive	Normal	Very resistant	Never had a problem
	When did you last expose yourself to the sun or artificial sun treatments?	More than 3 months ago	2-3 month ago	1-2 months ago	Less than 1 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					

- 00-07 points = Skin type I
- 08-16 points = Skin type II
- 17-25 points = Skin type III
- 25-30 points = Skin type IV
- 30-40 points = Skin types V and VI

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FACE BODY AESTHETIC SOLUTIONS

Photo and Video Release Form

I, hereby give my permission to (**physician/Company**) _____ and his/her employees, or any person, firm or organization that he/she may designate to take photographs, digital images and/or videos of me (**patient name**) _____ or if applicable my (**son/daughter name**) _____

This consent includes the use of such photographs, images or videos without my name for procedure evaluation, patient discussion and medical educational purposes regarding the aesthetic procedure. Additional acceptable uses for such images and videos are initialed below.

1. Photo book _____
2. Website or social media sites _____
3. TV broadcast _____
4. Digital/print article or publication _____
5. Advertisement _____

_____ _____
(Patient Name) (Name of Parent/Guardian if applicable)

_____ _____
(Signature) (Date)

_____
(Witness Name)

_____ _____
(Witness Signature) (Date)

CUTERA FACE + BODY AESTHETIC SOLUTIONS

Juliet™
Laser Treatment For Vaginal Health

PATIENT INFORMED CONSENT FORM TEMPLATE

Juliet Laser for Vaginal Health

***(NOTE: THIS PATIENT INFORMED CONSENT TEMPLATE IS PROVIDED "AS IS" AND IS INTENDED FOR INFORMATIONAL PURPOSES ONLY. THIS TEMPLATE MAY NOT MEET ALL STATE AND FEDERAL LEGAL OR REGULATORY REQUIREMENTS FOR USE WITH PATIENTS. PHYSICIANS USING THIS TEMPLATE ARE RESPONSIBLE FOR ENSURING THE INFORMED CONSENT FORM USED WITH PATIENTS MEETS ALL APPLICABLE STATE AND FEDERAL LEGAL AND REGULATORY REQUIREMENTS, AND ARE ENCOURAGED TO CONSULT WITH THEIR ATTORNEY.)**

I hereby authorize Dr._____ or _____, under Dr. _____'s supervision to perform the Juliet Laser treatment. The Juliet is an Er:YAG 2940 nm laser incorporating a unique treatment protocol delivering two passes to the vaginal area to stimulate collagen and revitalize the vaginal tissue to address symptoms associated vaginal atrophy and vaginal relaxation. The laser can treat the labia and vulvar tissue to improve the appurtenance and dyschromia in vulvar area. It may take multiple treatments to obtain optimal results, and it is possible that the results will be minimal or not help at all. The results may be temporary or permanent and there is no way to predict how long the results will last. Although these devices are effective in most cases, no guarantees can be made.

The procedure may result in the following adverse experiences or risks:

- **DISCOMFORT/PAIN –** Some discomfort and/ or pain may be experienced during treatment. A topical anesthetic will be applied to your skin before external vaginal treatment. Other forms of anesthesia, or pain management, may also be used.
- **PINK DISCHARGE/SPOTTING –** Pink discharge or spotting may be present for 3-4 days post-treatment.
- **INFECTION –** Infection is a possibility whenever the skin surface is disrupted which can lead to scarring. Proper wound care and keeping the treated area clean are important. If signs of infection develop, such as pain, heat, blisters, or surrounding redness, please call our office _____(Phone number)_____.
- **CONTACT/ALLERGIC DERMATITIS OR SKIN SENSITIVITY –** Potential increased sensitivity, irritation/itching or allergic reaction of the skin due to skin surface disruption.
- **ALLERGY –** There is a risk of an allergic reaction to the numbing cream.
- **EYE EXPOSURE –** Protective eyewear (shields) will be provided to you during the treatment. Failure to wear eye shields during the entire treatment may cause severe and permanent eye damage.

I acknowledge the following points have been discussed with me:

- Potential benefits of the proposed procedure, including the possibility that the procedure may not work for me
- Alternative treatments
- Reasonably anticipated health consequences if the procedure is not performed
- Possible complications/risks involved with the proposed procedure and subsequent healing period
- Instructions to refrain from intercourse for at least 72 hours post-treatment
- Instructions to avoid hot tubs, baths or swimming for a few days post treatment
- Post-treatment care instructions

For women of childbearing age: By signing below I confirm that I am not pregnant and do not intend to become pregnant anytime during the course of treatment. Furthermore, I agree to keep Dr._____ and staff informed should I become pregnant during the course of treatment.

☐ I certify that I have received an up-to-date (within 6 months) and normal PAP test and gynecologic exam.

☐ I certify that I am not menstruating at the time of treatment.

☐ I certify that I do not have any active infections in the treatment area.

Photographic documentation may be taken. I hereby ☐ do ☐ do not authorize the use of my photographs for teaching purposes.

ACKNOWLEDGMENT
BY MY SIGNATURE BELOW, I ACKNOWLEDGE THAT I HAVE READ AND FULLY UNDERSTAND THE CONTENTS OF THIS INFORMED CONSENT FOR THE JULIET LASER TREATMENT, AND THAT I HAVE HAD ALL MY QUESTIONS ANSWERED TO MY SATISFACTION BY MY HEALTHCARE TEAM.

Signature-Patient	**Print Name**	**Date**
Signature-Witness	**Print Name**	**Date**

Juliet

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RECOMMENDED PRE & POST CARE FOR JULIET AESTEHTIC TREATMENTS

For best results please follow these instructions

***NOTE: THIS PATIENT PRE & POST CARE TEMPLATE IS PROVIDED "AS IS" AND IS INTENDED FOR INFORMATIONAL PURPOSES ONLY. THE PHYSICIAN SHOULD REVIEW AND CUSTOMIZE.**

BEFORE YOUR TREATMENT:

- Do not wear makeup on the day of treatment
- Excess hair may need to be shaved. Men should be cleanly shaved
- No sun-tanning or self-tanners 4 weeks prior to treatment
    - Includes spray tans, tanning lotions, tanning beds, sun exposure, etc.
- Avoid treatments that may irritate the skin for 1-2 weeks prior to treatment (waxing, depilatories, skin products that contain irritants such as Vitamin A, tretinoin, retinol, benzoyl peroxide, glycolic/salicylic acids, astringents, etc.)
- Notify clinic with any changes to your health history or medications since your last appointment
- History of herpes or cold sores may require an anti-viral prescription prior to treatment

AFTER YOUR TREATMENT:

- Over-the-counter pain medication or cool compress is recommended if you experience minor pain/discomfort post-treatment
- Regularly wash area with a non-irritating skin cleanser and apply a healing ointment (such as Aquafor) until treated area has fully healed
- Redness, swelling and crusting may occur and resolve with time
- Avoid sun exposure and use a broad spectrum (UVA/UVB) sunscreen to prevent further sun damage
- Do not shave, wax or use depilatory creams in the treatment area for a few days
- Avoid heat – hot tubs, saunas, etc. for 1-2 days
- Avoid skin irritants (examples below) a few days post-treatment
    - Avoid products containing tretinoin, retinol, benzoyl peroxide, glycolic/salicylic acids, astringents, etc.
- Multiple treatments are required
- Makeup can be applied _____ days post-treatment.
- Notify clinic of any concerns (blistering, excessive redness/swelling, itching, etc.)
- Additional instructions: _____

_____

Clinic:_____

Contact at Clinic: _____

Clinic Phone Number: _____

Share your positive treatment experience by posting treatment reviews and before & after images on RealSelf @ https://www.realself.com/review/write/

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