

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)

- | | | |
|--|--|--|
| <input type="checkbox"/> BOTOX | <input type="checkbox"/> SUN DAMAGE | <input type="checkbox"/> SKIN CARE ADVICE / PRODUCTS |
| <input type="checkbox"/> FILLERS | <input type="checkbox"/> CELLULITE REDUCTION | <input type="checkbox"/> MICRODERMABRASION |
| <input type="checkbox"/> ROSACEA | <input type="checkbox"/> SKIN TIGHTENING | <input type="checkbox"/> FACIAL/LEG VEIN TREATMENTS |
| <input type="checkbox"/> ACNE TREATMENTS | <input type="checkbox"/> FAT REDUCTION | <input type="checkbox"/> HAIR REMOVAL |
| <input type="checkbox"/> FINE LINES/WRINKLES | <input type="checkbox"/> TATTOO REMOVAL | <input type="checkbox"/> 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)

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

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: _____

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)

PATIENT INFORMED CONSENT FORM TEMPLATE

Juliet Laser for Aesthetic Skin Resurfacing

***(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 for the purpose of skin peeling, resurfacing and/or skin revitalization. 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 treatment. Other forms of anesthesia, or pain management, may also be used.
- **SWELLING** – Swelling (edema) of the treated area is common and may occur. This usually resolves in a few days.
- **REDNESS** – Redness (erythema) of the treated area is common and may occur. This usually resolves in a few days.
- **SKIN COLOR CHANGES** – During the healing process, there is a possibility that the treated area may become either lighter (hypopigmentation) or darker (hyperpigmentation) in color compared to the surrounding skin. This is usually temporary, but, on a rare occasion, it may be permanent. You should avoid sun exposure after the treatment and use sunblock.
- **MILIA/ACNE** – Ointments that occlude hair follicles, sweat ducts, or sebaceous ducts may lead to milia/acne formation. This is more common in individuals with a history of cystic acne or oily skin.
- **WOUNDS** – Treatment can result in burning, blistering, or bleeding of the treated areas. It is important that you not pick or scratch the sites as this may lead to permanent scars or promote an infection. If any of these occur, please call our office.
- **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.
- **SCARRING** – Scarring is a rare occurrence, but it is a possibility if the skin surface is disrupted. To minimize the chances of scarring, it is IMPORTANT that you follow all post-treatment instructions provided by your healthcare staff.
- **TREATMENT PATTERN** – A persistent spot size pattern may be apparent on the treated skin and usually resolves with time. In rare cases, it may be permanent.
- **ALLERGY** – There is a risk of an allergic reaction to the numbing cream.

RECOMMENDED PRE & POST CARE FOR JULIET AESTHETIC 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/>