## STUART LIPTON CLIENT CONSULTATION FORM

Date:						Desired Treatment Abdomen	nt Areas: (circle) Chest	Face (side	e) Legs
						Arms (fore/under)		Face (full Hairline	) Back
Name:					<del></del>	Neck (front/back) Bikini Line	Ears Hands	Eyebrows	Nose Breast
Address:						Private Areas	Feet/Toes	Upper Lip	
City:						Current Evaluation	on of Skin/Hair ents: (circle all that	annly)	
State:	Zip:	I	OOB:				inis. (circic un tinut	uppij)	
Home Phone:		V	Vork Phone:			Electrology Depilatories	Shaving Tweezing	Laser Waxing	Electric Tweezers Cosmetic Peel
Referred By:						Existing Skin Con	ditions:		
Medical: In the l	ast 5 years	s have you				Scarring Pigmenta			Telangiectasia
Accutane	No	Yes		No	Yes	Rash Permane	nt Make Implants	8	Tattoo
Acne	No	Yes		No	Yes				
Canker Sores	No	Yes		No	Yes	General Skin Cond	lition:Normal	_Normal to	dryDryOily
Carcinoma	No	Yes	- F	No	Yes				
Cold Sores	No	Yes	High Blood Pressure		Yes	Have you ever been	n treated by an endo	ocrinologist	?NoYes
Contact Lenses	No	Yes		No	Yes				
Moles	No	Yes	Dermatitis/Eczema		Yes	Information on Ta	anning and Healin	g: (circle)	
Diabetes	No	Yes	Metal Pins In Body		Yes			n : 1 . 6	1 37 - 0 1 - 11
Pacemaker	No	Yes	1	No	Yes	How easily do you	tan? Very Good	Fairly Good	d Not Good at all
Latex Allergies	No	Yes		No	Yes		10 11 0 1	T . 1 . 6	
Glycolic Acids	No	Yes		No	Yes	How well do you h	eal? Very Good	Fairly Good	d Slow Healer
Retin A	No	Yes	EDTA Chelation	No	Yes				
Alpha Hydroxy	No	Yes				Do you have any M	1edical Problems?		
Are you currentl	y taking a								
Tetracycline Bactrim Hydrochlorothiazide				ıde	Taking any type of drugs?No				
If you answered yes to any of the above, please explain:					If yes please describe by name				
							you like to begin ha		
Female Client M	edical Info	ormation	:			110W Soon Would y	ou like to begin ha	an remova	
In Menopause	No	Yes	Birth Control Pills	No	Yes	Very Soon	Near Future	Today if I	Possible
Hormone Pills	No	Yes	Post Menopause	No	Yes	31, 5001		- 0 44 5 11 1	- ~~~~ <b>*</b>
Pregnant	No	Yes	Regular Periods	No	Yes				
PMS	No	Yes	Endocine Problems	No	Yes				
Painful Periods	No	Yes	Hormone Imbalance	e No	Yes				
Other?	No	Yes	Explain:						

## Consent Form

I autl	horize (healt	hcare professional's	s name)	to perform Laser/IPL treatments		
on _			with the			
	Vbeam	Smoothbeam	GentleLASE	GentleYAG_	IPL	
To tr	eat my cond	ition, which is calle	d:			_

The Laser / IPL is a device that produces an intense but gentle burst of light. This light is absorbed by and causes selective heating of certain cells in your unwanted lesion. Lesions most commonly fade slowly over time as these destroyed cells are eliminated by normal body processes.

My eyes will be covered with laser / IPL -specific safety eyewear or an opaque material to protect them from the intense light. My eyes will be closed and I will not attempt to remove the eye protection during treatment.

I have been informed of the following possible risks and complications of this procedure including but not limited to:

(circle all that apply):

Purpura (red-purple discoloration, bruising)

Itching (hive-like response which lasts 2-3 hours to 2-3 days)

Herpes simplex virus activation

Burns, blisters, scabbing, crusting, skin color and /or textural changes

Hyperpigmentation (darkening of the skin; transient or long term))

Hypopigmentation (lightening of the skin; transient, long term or possibly permanent)

Scarring (rare, possibly permanent)

I understand that complete clearing may not be possible and will depend upon the type, age and color of the lesion. Multiple treatments may be needed for the best results.

Other methods of treating this condition have been discussed with me such that I may assess the risks and benefits of these alternative treatment methods.

If oxygen is used during my treatment, my provider will ensure that it is used safely. Oxygen supports combustion and may cause flash burns in the treatment area.

Anesthesia is usually not necessary. My provider or I may elect to use a form of topical anesthesia to reduce any discomfort during the procedure. A cryogen spray skin cooling device may be used during the procedure to decrease discomfort and protect the skin. All anesthesia options and risks will be discussed with me in advance.

I understand that immediately following the laser treatment redness, swelling, discomfort, bruising, and discoloration may develop at the treatment site. I understand that any discoloration may last 7-14 days and swelling should resolve within several days. Discomfort may be treated with the application of cool compresses or topical soothing agents.

after care instructions carefully to minimize t	ng after care of the treated area .It is important to follow the chance of incomplete healing ,skin textural changes or block may be recommended. Tanning should be avoided.			
	during the course of my laser therapy for healthcare records. medical education and /or marketing purposes.			
I have been given the opportunity to ask questand I understand the information given to me	stions about the procedure. My questions have been answered			
Contraindications to the performance of this procedure have been discussed in detail with me.				
I recognize that the practice of medicine is no been made to me concerning the results of su	ot an exact science and acknowledge that no guarantees have ch procedures.			
I have read and understood all information pr	resented to me before signing this consent form.			
Signed:	Date:			
Witness:	Time:			