STUART LIPTON
CLIENT CONSULTATION FORM

Date: _____

Name: _____

Address: _____

City: _____

State: _____ Zip: _____ DOB: _____

Home Phone:_____ Work Phone: _____

Referred By: _____

Medical: In the last 5 years have you used or had?

Accutane	No	Yes	Hearing Aid	No	Yes
Acne	No	Yes	Heart Condition	No	Yes
Canker Sores	No	Yes	Hemophilia	No	Yes
Carcinoma	No	Yes	Hepatitis	No	Yes
Cold Sores	No	Yes	High Blood Pressure	No	Yes
Contact Lenses	No	Yes	Keliod Scars	No	Yes
Moles	No	Yes	Dermatitis/Eczema	No	Yes
Diabetes	No	Yes	Metal Pins In Body	No	Yes
Pacemaker	No	Yes	Genital Herpes	No	Yes
Latex Allergies	No	Yes	Tuberculosis	No	Yes
Glycolic Acids	No	Yes	Gold Treatments	No	Yes
Retin A	No	Yes	EDTA Chelation	No	Yes
Alpha Hydroxy	No	Yes			

Are you currently taking any of the following drugs:

Tetracycline Bactrim Hydrochlorothiazide

If you answered yes to any of the above, please explain:

_____

_____

Female Client Medical Information:

In Menopause	No	Yes	Birth Control Pills	No	Yes
Hormone Pills	No	Yes	Post Menopause	No	Yes
Pregnant	No	Yes	Regular Periods	No	Yes
PMS	No	Yes	Endocine Problems	No	Yes
Painful Periods	No	Yes	Hormone Imbalance	No	Yes
Other?	**No**	**Yes**	**Explain:**		

_____

____

_____

Desired Treatment Areas: (circle)

Abdomen	Chest	Face (side)	Legs
Arms (fore/under)	Chin	Face (full)	Back
Neck (front/back)	Ears	Hairline	Nose
Bikini Line	Hands	Eyebrows	Breast
Private Areas	Feet/Toes	Upper Lip	Fingers

Current Evaluation of Skin/Hair
Previous Treatments: (circle all that apply)

Electrology	Shaving	Laser	Electric Tweezers
Depilatories	Tweezing	Waxing	Cosmetic Peel

Existing Skin Conditions:

Scarring	Pigmentation	Acne	Telangiectasia
Rash	Permanent Make	Implants	Tattoo

General Skin Condition: __Normal ___Normal to dry __Dry __Oily

Have you ever been treated by an endocrinologist? ___No _____Yes

Information on Tanning and Healing: (circle)

How easily do you tan? Very Good Fairly Good Not Good at all

How well do you heal? Very Good Fairly Good Slow Healer

Do you have any Medical Problems?

_____

Taking any type of drugs? _____Yes _____No

If yes please describe by name

_____

How soon would you like to begin hair removal?

Very Soon Near Future Today if Possible

Consent Form

I authorize (healthcare professional's name)_____to perform Laser/IPL treatments on _____with the
_____Vbeam_____Smoothbeam_____GentleLASE_____GentleYAG_____IPL
To treat my condition, which is called:_____

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.

I will be given complete instructions regarding after care of the treated area .It is important to follow after care instructions carefully to minimize the chance of incomplete healing ,skin textural changes or scarring. Sun avoidance and /or use of a sunblock may be recommended. Tanning should be avoided.

_____I have provided my past and current medical history and medications.
_____I consent to the taking of photographs during the course of my laser therapy for healthcare records.
_____I consent to using my photographs for medical education and /or marketing purposes.
My name will not be used to identify these photographs.
_____I am not pregnant (female patients).

I have been given the opportunity to ask questions about the procedure. My questions have been answered and I understand the information given to me.

Contraindications to the performance of this procedure have been discussed in detail with me.

I recognize that the practice of medicine is not an exact science and acknowledge that no guarantees have been made to me concerning the results of such procedures.

I have read and understood all information presented to me before signing this consent form.

Signed: _____Date:_____

Witness: _____Time:_____