Medical History

Name: _____

Address: _____

City, State, Zip: _____

Home Phone: _____ Work: _____ Cell: _____

Date of Birth: _____Age: _____ Referred by: _____

Email Address: _____

Have you ever had the following?

- ☐ Current or history of cancer, especially malignant melanoma or recurrent non-melanoma skin cancer, or pre-cancerous lesions such as multiple dysplastic nevi.
- ☐ Any active infection.
- ☐ Diseases which may be stimulated by light at 515 nm to 1200 nm, such as history of recurrent Herpes Simplex, Systemic Lupus Erythematosus, or Porphyria.
- ☐ Use of photosensitive medication and/or herbs that may cause sensitivity to 515 - 1200 nm light exposure, such as Isotretinoin, tetracycline, or St. John's Wort.
- ☐ Immunosuppressive diseases, including AIDS and HIV infection, or use of immunosuppressive medications.
- ☐ Patient history of Hormonal or endocrine disorders, such as polycystic ovary syndrome or diabetes, unless under control.
- ☐ History of bleeding coagulopathies, or use of anticoagulants
- ☐ History of keloid scarring.
- ☐ Very dry skin.
- ☐ Exposure to sun or artificial tanning during the 3–4 weeks prior to treatment.
- ☐ Are you pregnant? ☐ Yes ☐ No
- ☐ What medications are you taking (including aspirin)?
- ☐ Daily consumption of alcohol
- ☐ Allergies: _____
- ☐ Are you taking any herbal preparations? (St. John's Wort, etc.) If yes, list
- ☐ Do you wear contact lenses? ☐ Yes ☐ No

Skin type (when exposed to the sun without protection for about 1 hour)

☐ always burns, never tans ☐ always burns, sometimes tans

☐ sometimes burns, sometimes tans ☐ always tans

☐ Hispanic ☐ Asian ☐ Mediterranean ☐ Middle Eastern ☐ Black

When were you last exposed to the sun (including tanning booth)? _____

Do you use chemical sun tanning lotions? _____ Are you planning a holiday in the sun? _____

Reason for visit (area to be treated) _____

Prior treatment (if any)

Electrolysis Consent Form

Patient Name: _____

Treatment Sites: _____

I duly authorize Sarasota Laser to perform the following electrolysis procedure and any other measures which in their opinion may be necessary:

_____

Clinical results may vary depending on individual factors, including medical history, skin type, patient compliance with pre/post treatment instructions, and individual reponse to treatment.

I understand that the treatment involves a series of treatments and the fee structure has been fully explained to me_____ (**patient's initials)**.

I certify that I have been fully informed of the nature and purpose of the procedure, expected outcomes and possible complications, and I understand that no guarantee can be given as to the final result obtained. I am fully aware that my condition is of cosmetic concern and that the decision to proceed is based solely on my expressed desire to do so.

I confirm that I am not pregnant at this time, and that I have not taken Accutane within the last 6 months.

I consent to the taking of photographs and authorize their anonymous use for the purposes of medical audit, education and promotion.

I certify that I have been given the opportunity to ask questions and that I have read and fully understand the contents of this consent form.

Patient Signature: _____

Date: _____

Witness: _____