LASER HAIR REMOVAL

PATIENT PRETREATMENT QUESTIONNAIRE

Name:_____

PLEASE ANSWER THE FOLLOWING QUESTIONS:

1. Which phrase best describes your skin type?
   _____ I- always burns, never tans
   _____ II- always burns, sometimes tans
   _____ III- sometimes burns, always tans
   _____ IV- rarely burns, always tans
   _____ V- moderately pigmented (Hispanic, Asian, Mediterranean, Middle Eastern)
   _____ VI- African American

2. Do you have a history of keloids or unusual scarring? _____yes _____no

3. Do you have a history of Herpes simplex (fever blisters, cold sores) recurring in the area to be treated?
   _____yes _____no

4. Have you been on Accutane (isotretinoin) in the last six months? _____yes _____no

5. Do you take Propecia or apply topical Rogaine for hair loss? _____yes _____no

6. Do you use Retin-A/Renova/Differin, glycolic acid products or hydroquinone (bleaching agent) on the treated area? _____yes _____no

7. Have you had waxing, plucking or electrolysis performed on the area(s) to be treated in the preceding six weeks? _____yes _____no

8. When were you last exposed to the sun (including tanning booths)? _____

   _____

   _____

9. Do you use sunless tanning lotions? _____yes _____no When was it last applied? _____

   _____

   _____

10. Are you planning a holiday in the sun? _____yes _____no

11. Are you pregnant? _____yes _____no _____

    _____

12. Please list any medications, including hormones, you are currently taking:? _____

_____

13. List any medication allergies: _____

14. Have you ever received permanent make-up (eyeliner, lip liner, blush, eyebrow color)? _____yes _____no
If so where? _____

15. Do you have any tattoos (medical, cosmetic, decorative, or traumatic) in the area to be treated? _____yes
____no If so where? _____

16. Have you ever received treatment with gold (gold therapy)? _____yes _____no

17. Have you ever been checked for hormone problems or have you ever been seen by an endocrinologist?
_____yes _____no

18. Are you currently being treated for a condition not listed? If so, please explain:

19. What products are you currently using on your skin? _____

_____

_____

20. Have you ever had a chemical peel? If so what type and when? _____

_____

_____

21. Have you ever had any laser hair removal treatments before? _____yes _____no _____

_____

INFORMED CONSENT FOR LASER HAIR REMOVAL

The Light Sheer XC is a diode laser for the removal of unwanted hair. Only actively growing hairs and follicles are affected and several treatments are necessary.

I am aware that there are alternate treatments including waxing and electrolysis.

The treatments, expectations from the treatment, and post treatment care have been explained to me and my questions regarding the treatment have been answered to my satisfaction._____

I understand that the laser works on actively growing hairs and follicles and not on any that are dormant. For this reason, it requires several sessions to complete a course of treatment. I understand that the goal of treatment is long-term hair reduction, and that permanent hair removal may or may not occur._____

I am aware of the following possible risks associated with this treatment including, but not limited to:

* **Discomfort** – Some discomfort may be experienced during laser treatment. Topical anesthesia may be used if necessary.

* **Wound healing** – Laser surgery may result in swelling, blistering, crusting or flaking of the treated area, which may require days to weeks to completely heal. Skin irritation, pimple-like red or white bumps, and dryness of the skin are common, but temporary. Rarely, bruising may occur. Once the surface has healed, it may be pink and sensitive to the sun for an additional 2 – 4 weeks.

* **Pigment changes** (skin color) – During the healing process, the treated areas may become darker or lighter than the surrounding skin. This is usually temporary but, on rare occasions, may be permanent.

* **Infection** – skin infections can occur any time the skin surface is broken.

* **Scarring** – Scarring is a rare occurrence.

* **Vellus hair growth** – Occasionally fine blonde hairs may grow in a treated area. These hairs may not respond to further laser treatment.

* **Gray or Blonde** hairs responds poorly to laser treatment.

* **Rare instances of increased hair growth after laser hair treatment have been reported.**

* **No effect** – Rarely, some patients may not respond to laser hair removal.

* **Eye exposure** – Protective eyewear will be provided. It is important to keep the protective eyewear on at all times during the procedure. _____

Pre-treatment and post treatment photographs will be obtained. I agree that any photographs taken may be used for medical publication or teaching purposes for medical, paramedical or lay persons. I understand that the release of this information will be kept confidential and that my name will not be released. _____

Due to the nature of this treatment, an exact result cannot be predicted and I acknowledge that no guarantees have been made to me as to the results that may be obtained._____

I certify that I have read this entire consent form and that all of my questions have been answered, and I understand and agree to the information provided above. I consent to and authorize Dr. Joseph Bianca and members of his staff to perform Laser Hair Removal.

_____ _____

Patient signature or legal guardian **Date**

_____ _____

Witness **Date**