



**Client Information for Esthetic Consultation**

(Please Print)

Name: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_ Email: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Social Security #: \_\_\_\_\_

Age: \_\_\_\_\_ Sex: \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_

Dermatologist: \_\_\_\_\_

**Spouse/ Parent/ Next of Kin**

Name: \_\_\_\_\_

Relationship: \_\_\_\_\_

Address if different than above: \_\_\_\_\_

\_\_\_\_\_

Contact Phone Number: \_\_\_\_\_

In Case of Emergency Contact: \_\_\_\_\_

\_\_\_\_\_

Who may we thank for referring you? \_\_\_\_\_



## Palomar StarLux™ Informed Consent

I authorize REINA RENA to perform pulsed light treatments of the following:

\_\_\_\_ **Hair Removal:**

Area to be treated: \_\_\_\_\_

\_\_\_\_ **Photofacial/RejuveLux™:**

\_\_\_\_ Sun or age spots:

Area to be treated: \_\_\_\_\_

\_\_\_\_ Vascular lesions ( i.e. spider veins, rosacea):

Area to be treated: \_\_\_\_\_

\_\_\_\_ Acne/Scarring:

Area to be treated: \_\_\_\_\_

I understand that the procedure is purely elective and not covered by insurance. I understand that I am responsible for all costs of treatment.

I understand that: Serious complications are rare, but possible. Common side effects include temporary redness and mild "sunburn" like effects that may last a few hours to 3-4 days or longer. Other potential risks include blistering, crusting, itching, pain, bruising, skin whitening, burns, infection, scabbing, scarring, and swelling. Treatment of pigmented lesions and vascular lesions cannot be accomplished without producing some epidermal change and that this may take 2-4 weeks to resolve. Some pigmented changes (lighting or darkening of spots on the skin) lasting 1-6 months or longer may occur. In addition, freckles may lighten and/or temporarily or permanently disappear in treated areas. There is a likelihood of coincidental hair removal when treating pigmented/vascular lesions in hair bearing areas. Intense light can cause eye injury, and protective eyewear must be worn during treatment at all times.

I understand that this procedure may fail to remove all the unwanted hair in some cases, especially hair that is not pigmented. Therefore, I understand there is no guarantee or reimbursement. Successful hair removal and/or significant reduction usually occurs in 6-8 sessions, but in some cases more treatments may be required. For long term results, a periodic maintenance treatment, depending on your body's natural hair re-growth cycle will be necessary.

I understand that I must be completely honest in divulging my exposure, whether direct or indirect, to sun exposure, the use of tanning lamps and/ or self tanning creams may increase my chance of complications. I also understand that not adhering to the post-care instructions provided to me may increase my chance of complications.

I consent to the use of photographs for treatment evaluation. No photographs revealing my identity will be used without my written consent. If my identity is not revealed, these photographs may be used and displayed publicly without my permission.

Before and after treatment instructions have been discussed with me. The procedure as well as potential benefits and risks have been explained to my satisfaction. I have had all my questions answered and freely consent to the proposed treatment.

Patient's Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Witness Signature: \_\_\_\_\_

Date: \_\_\_\_\_

# Medical History

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

**Yes**    **No**

1. Do you have any current or chronic medical illnesses? \_\_\_\_\_

Please List: \_\_\_\_\_

2. Have you had any surgeries (include cosmetic)? \_\_\_\_\_

3. Do you take any medications (orally or topical) on a regular or daily basis? \_\_\_\_\_

Please list: \_\_\_\_\_

4. Do any medications that you are currently taking cause photosensitivity?  
(both prescriptive and non-prescriptive including herbal and natural remedies) \_\_\_\_\_

Please list: \_\_\_\_\_

5. Are you currently taking or using any of the following medications or supplements:  
(Please check and list how recent)

\_\_\_ Birth Control \_\_\_\_\_      \_\_\_ Accutane (oral acne drug) \_\_\_\_\_

\_\_\_ Coumadin® \_\_\_\_\_      \_\_\_ St. John's Wort \_\_\_\_\_

\_\_\_ Heparin® \_\_\_\_\_      \_\_\_ Tretinoin (Retin-A/Renova/AHA's/BHA'S) \_\_\_\_\_

\_\_\_ Aspirin \_\_\_\_\_      \_\_\_ anti-coagulant remedies \_\_\_\_\_

\_\_\_ Garlic \_\_\_\_\_      \_\_\_ anti-platelet remedies \_\_\_\_\_

\_\_\_ Ginger \_\_\_\_\_      \_\_\_ Prescription Acne medications  
brand? \_\_\_\_\_

\_\_\_ Cayenne \_\_\_\_\_      \_\_\_ Ginkgo/GinkgoBiloba/Selenium \_\_\_\_\_

\_\_\_ Papaya \_\_\_\_\_      \_\_\_ Vitamin A/ Vitamin E \_\_\_\_\_

\_\_\_ Bilberry \_\_\_\_\_      \_\_\_ other vitamin or herbal supplements:  
\_\_\_\_\_

6. Do you have any of the following condition? Check if yes.  
(if any, please list medications oral or topical)

\_\_\_ Allergies (to medications/latex/foods/other): \_\_\_\_\_

\_\_\_ Arthritis \_\_\_\_\_      \_\_\_ Cold sores \_\_\_\_\_

\_\_\_ Diabetes \_\_\_\_\_      \_\_\_ Herpes \_\_\_\_\_

\_\_\_ Migraines \_\_\_\_\_      \_\_\_ Thyroid Problems \_\_\_\_\_

\_\_\_ Seizures \_\_\_\_\_      \_\_\_ Active Infections \_\_\_\_\_

\_\_\_ Immunosuppression \_\_\_\_\_      \_\_\_ Other conditions not listed above:  
\_\_\_\_\_

- |  | <u>Yes</u> | <u>No</u> |
|--|------------|-----------|
| 7. Are you currently taking medication for Hormone Replacement Therapy?<br>If yes, please list: _____            | ___        | ___       |
| 8. Do you suffer from Hirsutism?   | ___        | ___       |
| 9. Are you currently being treated with Chemotherapy?  | ___        | ___       |
| 10. Do you have a history of Keloid and Hypertrophic scarring?   | ___        | ___       |
| 11. Do you have any permanent make-up, metal implants, pins, or tattoos?<br>If yes, please list locations: _____ | ___        | ___       |
| 12. Are you Pregnant/Lactating?  | ___        | ___       |
| 13. Are your menstrual periods regular?  | ___        | ___       |
| 14. Have you used any Glycolic or Alpha Hydroxy Acid products in the past week?                                  | ___        | ___       |
| 15. Are you exposed to the sun on a daily basis?   | ___        | ___       |
| 16. Do you work near a UV source?  | ___        | ___       |
| 17. Do you use a tanning bed?  | ___        | ___       |
| 18. Please list any allergic reactions you may have had with a skin care product:<br><br>_____                   |            |           |
| 19. When was your last facial? _____   |            |           |
| 20. List your menstrual cycle due date: _____  |            |           |
| 21. Please list daily consumption:<br><br>Alcohol _____ Caffeine _____ Tobacco _____                             |            |           |

**To determine skin type, check one of the following:**

	<u>Type</u>	<u>Color</u>	<u>Reaction to first sun exposure yearly</u>
___	I	white	always burn/never tans
___	II	white	usually burns/tans with difficulty
___	III	white	sometimes mild burn/average tan
___	IV	asian or moderate brown	rarely burns/tans with ease
___	V	dark brown	very rarely burns/tans very easily
___	VI	black	never burns

Signature: \_\_\_\_\_

Date: \_\_\_\_\_