

## Personal Profile and Health History

Name: \_\_\_\_\_ Home Phone: \_\_\_\_\_

Address: \_\_\_\_\_ Work Phone: \_\_\_\_\_

City/State/Zip: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Gender: M \_\_\_ F \_\_\_

Occupation: \_\_\_\_\_ Email address: \_\_\_\_\_

How did you hear about us? \_\_\_\_\_

What cosmetic/aesthetic procedures are you interested in?

\_\_\_\_\_

Please share any questions, concerns or comments: \_\_\_\_\_

**Females:** Are you pregnant?  Yes  No Are you breastfeeding?  Yes  No

Are you planning pregnancy during the course of your treatment?  Yes  No

*Your genetic background affects your skin and its response to the laser. Please specify your ethnic origin:*

African American  Asian  Caucasian  Hispanic  Mediterranean

Middle Eastern  Native American  Other \_\_\_\_\_

Please complete the following items of medical history. Please, always inform us of any change in your medical history and/or medications. Please list **all** medications including prescription and over the counter drugs, vitamins, herbs, supplements.

\_\_\_\_\_

Are you allergic to any medications?  Yes  No Please list medications and reactions. \_\_\_\_\_

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Acne                      | <input type="checkbox"/> High Blood Pressure    | <input type="checkbox"/> Permanent Makeup   |
| <input type="checkbox"/> Bleeding Disorders        | <input type="checkbox"/> Hirsutism              | <input type="checkbox"/> Precocious Puberty |
| <input type="checkbox"/> Burns/Skin Grafts         | <input type="checkbox"/> Hormone Replacement Rx | <input type="checkbox"/> Psoriasis          |
| <input type="checkbox"/> Cold Sores/Fever Blisters | <input type="checkbox"/> Implants               | <input type="checkbox"/> Seizures           |
| <input type="checkbox"/> Diabetes                  | <input type="checkbox"/> Kaposi's Sarcoma       | <input type="checkbox"/> Shingles           |
| <input type="checkbox"/> Endocrine Disorders       | <input type="checkbox"/> Keloid Scars           | <input type="checkbox"/> Skin Cancer        |
| <input type="checkbox"/> Excessive Bleeding        | <input type="checkbox"/> Liver Disease          | <input type="checkbox"/> Tattoos            |
| <input type="checkbox"/> Gold Therapy              | <input type="checkbox"/> Lupus Erythematosus    | <input type="checkbox"/> Thyroid Disease    |
| <input type="checkbox"/> Heart Disease             | <input type="checkbox"/> Mental Disease         | <input type="checkbox"/> Vitiligo           |
| <input type="checkbox"/> Herpes                    | <input type="checkbox"/> Neuromuscular Disease  | <input type="checkbox"/> Other _____        |

## Personal Profile and Health History

Have you had surgery in the area to be treated? If "Yes", please explain

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**If the answer to any of the following questions is yes, please provide details in the space provided.**

Are you currently being treated for any medical conditions? Yes No

Explain: \_\_\_\_\_

Do you smoke? If so # per day? \_\_\_\_\_ Yes No

Do you drink alcohol? Amount per day? \_\_\_\_\_ Yes No

Have you used Accutane in the last 6 months? How recently? \_\_\_\_\_ Yes No

Do you have any active skin diseases or infection in the area to be treated? Yes No

Do you have any skin allergies? Yes No

Are you allergic to latex, lidocaine, or any lotions? Please circle any that apply Yes No

Are you currently using glycolic acid or Retin A? Please circle any that apply. Yes No

Have you had a chemical peel or facial within the last week? Yes No

What products are you currently using on your skin?

Describe: \_\_\_\_\_

Have you had any permanent cosmetic tattooing to the area to be treated? Yes No

Do you have any metal or other implants? Where? \_\_\_\_\_ Yes No

Have you had any previous laser treatment or other skin treatment to the area to be treated? Describe: \_\_\_\_\_ Yes No

Are there any moles with hair in the area to be treated? Yes No

Are you currently using or have used within the last six weeks a tanning bed or tanning cream? If yes, date of last use \_\_\_\_\_ Yes No

Have you been exposed to the sun within the last four to six weeks? Yes No

If yes, approximate date of last exposure \_\_\_\_\_

Name of your family doctor: \_\_\_\_\_ Phone No. \_\_\_\_\_

I confirm that the answers to the questionnaire are true and correct. I also confirm that the consultant has clarified any questions I did not understand.

Signature of Client: \_\_\_\_\_ Date: \_\_\_\_\_

Signature of Dr./ARNP/PA \_\_\_\_\_ Date: \_\_\_\_\_



Capital Medical Group

Capital Aesthetics

1001 Leawood Drive Suite A ♦ Frankfort, KY 40601 ♦ ph: 502.875.0872 fax: 502875.2387

FINANCIAL POLICY

Payment for Aesthetic Services is required at the time of service. These services are considered cosmetic in nature and therefore are not billable to health insurance plans.

Cancellations must be made 24 hours in advance of your appointment time. No shows or cancellations with less than 24 hours notice may result in a \$25 charge.

Please expect to pay in full for the service on the day it is performed.

We accept

CASH

CHECKS

Most Major Credit Cards: Visa, Master Card, American Express, Discover

CareCredit: no interest and extended payment plans subject to credit approval.

I acknowledge that I have read the financial policy above and understand that I am responsible for payment for my services at the time of service.

\_\_\_\_\_

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

# Skin Type Form

Skin type is often categorized according to the Fitzpatrick skin type scale, which ranges from very fair (skin type I) to very dark (skin type VI). The three main factors that influence skin type and the treatment program:

**Genetic disposition**

**Reaction to sun exposure**

**Tanning habits**

Skin type is determined genetically and is one of the many aspects of your overall appearance, which also includes color of eyes, hair, etc. The way your skin reacts to sun exposure is another important factor in correctly assessing your skin type. Recent tanning (sun bathing, artificial tanning or tanning creams) has a major impact on the evaluation of your skin color. Please help us determine your skin type and treat you the right way. Please take a few minutes to fill-out this questionnaire, **circling the most appropriate response.**

Name \_\_\_\_\_

### Genetic Disposition

Score	0	1	2	3	4
What is the color of your eyes?	Light blue, Gray, Green	Blue, Gray or Green	Hazel/ Brown	Dark Brown	Brownish Black
What is the natural color of your hair?	Sandy Red	Blond	Chestnut/ Dark Blond	Dark Brown	Black
What is the color of your skin (non-exposed areas)?	Reddish	Very pale	Pale Beige tint	Light Brown	Dark Brown
Do you have freckles on unexposed areas?	Many	Several	Few	Incidental	None

**Score for Genetic Disposition**

### Reaction to Sun Exposure

Score	0	1	2	3	4
What happens when you stay in the sun too long?	Painful redness, blistering, peeling	Blistering followed by peeling	Burns sometimes followed by peeling	Rare burns	Never burns
To what degree do you turn brown?	Hardly or not at all	Light color tan	Reasonable tan	Tan very easily	Turn dark brown quickly
Do you turn brown within several hours after sun exposure?	Never	Seldom	Sometimes	Often	Always
How does your face react to the sun?	Very Sensitive	Sensitive	Normal	Very resistant	Never had a problem

**Score for Reaction to Sun Exposure**

### Tanning Habits

Score	0	1	2	3	4
When did you last expose your body to sun (or artificial sunlamp/tanning cream)?	More than 3 months ago	2-3 months ago	1-2 months ago	Less than a month ago	Less than 2 weeks ago
When in the sun, do you expose the area to be treated?	Never	Hardly ever	Sometimes	Often	Always

**Score for Tanning Habits**

**What color is the hair in the area to be treated?** \_\_\_\_\_

	Skin Type Score	Skin Type	Skin Color
◀ Genetic Disposition Score			
◀ Reaction to Sun Exposure Score	0-7	I	Very fair, "transparent"
◀ Tanning Habits Score	8-16	II	Fair
◀ Total Score	17-25	III	Fair to light olive
◀ Skin Type	26-30	IV	Olive to brown
	Over 30	V-VI	Dark Brown – Black



Capital Aesthetics

## **Laser Hair Reduction Post Treatment Instructions**

### **Expectations Following Treatment:**

Remember, the hair will not fall out tonight...or tomorrow for that matter! It can take up to 3 weeks for the hair to fall away. You can help this process along by gentle use of a washcloth or loofa sponge 4-5 days after treatment.

Immediately following laser treatment, you may experience redness or minor swelling of the skin, similar to mild sunburn. These normal tissue effects are temporary and will usually disappear over the next twenty-four hours. A soothing aloe vera gel or cold packs may be used to ease any discomfort. Acetaminophen (Tylenol), or ibuprofen (Advil, Nuprin) may also reduce post treatment discomfort. Do not use aspirin.

A small percentage of individuals may experience blistering or peeling of the skin. The peeling is similar to the effects of sunburn and it is recommended that the peeling skin not be removed as it may lead to scarring. If the skin blisters, an over-the-counter antibiotic such as Neosporin may be helpful.

### **Precautions:**

Take care to prevent trauma to the treated area for the first 1-3 days following the treatment. Treat the area gently. Avoid rubbing, scratching, or picking at the treated areas. Avoid very hot showers or baths, soaking in a hot tub, or swimming in a chlorinated pool as it may irritate the skin. Pat the skin dry after bathing or showering.

Avoid direct sun exposure (natural and artificial) for 5-7 days following each treatment. Tanning beds and tanning creams should also be avoided between treatments. If the sun cannot be avoided, be sure to use a sun block with an SPF of 30 for the face and 15 or higher for the body to provide protection between treatments.

To prevent skin irritation, avoid applying makeup for 24 hours, if possible.

### **General Skin Care:**

- If dryness occurs, apply a thin layer of aloe vera to the treated area several times a day until evidence of dryness has dissipated.
- Shower as usual but remember the treated area might be a little temperature sensitive.
- If the skin is irritated or blistered following treatment, avoid use of exfoliants, loofa sponges or aggressive scrubbing during the healing phase and be especially careful if any peeling is present.
- Any irritated areas can be protected from clothing or jewelry with a non-adhesive dressing such as Telfa.

- During the treatment period, sun block should be used whenever the treated area is exposed to the sun. Sun tanning increases the melanin (pigment) in the skin and increases the risk for burns and blistering during treatment.
- Avoid shaving with a razor for the first 2-3 days after treatment. An electric razor may be used after 24 hours.

**\*No waxing, tweezing, bleaching or depilatories between treatments.**

### **Pre-Treatment Instructions for Next Treatment**

- The area being treated cannot be exposed to the sun for at least 2 weeks prior to treatment. Apply a broad spectrum (UVA/UVB) sunscreen of SPF 30 or higher to any treatment area prior to exposure to the sun.
- Treatment cannot be performed on areas with significant suntan or sunburn. Avoid direct exposure to the sun, tanning beds, or self-tanning lotions for a minimum of 2 weeks prior to treatment.
- The area to be treated should be shaved 24 hours before treatment. If the area to be treated has a heavy growth of hair, shave 12 hours prior to treatment.
- Do not wear makeup, deodorant, perfume, or powder on areas to be treated.

*If you have any questions or concerns during your treatment procedures, please do not hesitate to call the office.*

### **Personal Treatment Schedule**

	<b>Site 1</b>	<b>Site 2</b>	<b>Site 3</b>
Treatment Interval Period			
	<b>Appointment Dates</b> (on or about)		
Treatment 1			
Treatment 2			
Treatment 3			
Treatment 4			
Treatment 5			

The above schedule has been scientifically designed to give you the most effective treatment results. Your adherence to this schedule will help to ensure its success.

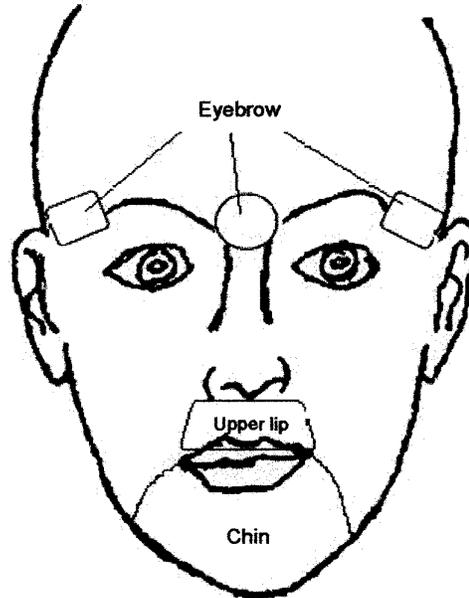
\* Minor adjustments can be made to accommodate your schedule and lifestyle without hindering the success rate of your treatments.

# Treatment Area Descriptions

**Eyebrows**=Mid-Brow and just outside the brow at the temple. Under the eyebrow will be considered on a per client basis. \_\_\_\_\_

**Upper Lip**=Corner to corner above the lip. \_\_\_\_\_

**Chin**=Front part of the chin from the lower lip to the underside of the jaw line. Width is the approximate size of the mouth and will include the throat. \_\_\_\_\_

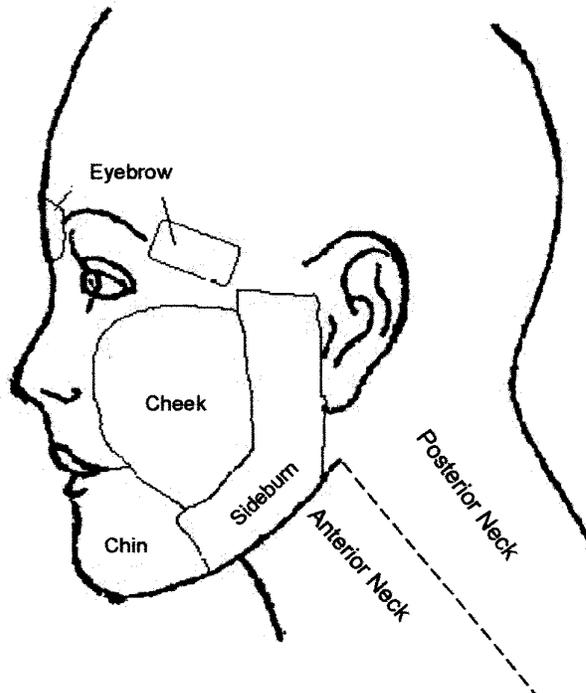


**Cheeks**=area adjacent to the sideburns, the full of the cheeks below eyes to the corner of the mouth. \_\_\_\_\_

**Sideburns**=Sculpted at approximately mid ear following down the jaw line to corner of approximately 2" wide. \_\_\_\_\_

**Anterior Neck**=Front of the neck from the jaw line to the hollow of the throat. \_\_\_\_\_

**Posterior Neck**=Back of the neck from the hairline to the collar line. \_\_\_\_\_



**Underarms**=Pit of the underarms \_\_\_\_\_

**Upper Arms**=Elbow to the top of the deltoid, front and back (does not include the underarm) \_\_\_\_\_

**Lower Arms**=The elbow down to the wrist, front and back includes the hands \_\_\_\_\_

**Hands**=From the wrist bones across the tops of hands and fingers \_\_\_\_\_

**Bikini**=3" outside of the panty line, a half an inch inside the panty line, and just across the top of the pubic hair. Treatment area includes 1" wide ab trail if wider than 1" price as lower abdomen \_\_\_\_\_

**Full Bikini (Brazilian)**=3" outside of the panty line, as much or as little sculpting inward, from the naval to the pubic area along the seam of the buttocks and into the anus area. Treatment includes 1" wide ab trail if wider than 1", price as lower abdomen \_\_\_\_\_

**Feet**=From the ankle bone onto the upper foot and toes \_\_\_\_\_

**Entire Legs**=Starting at the top of the leg where the bikini area ends down to and including the feet and toes. It does not include the hip or the side of the buttocks \_\_\_\_\_

**Upper Legs**=Right above the kneecap and will meet where the bikini line ends 3 inches away from the panty line and 3 inches away from the seam of the buttocks \_\_\_\_\_

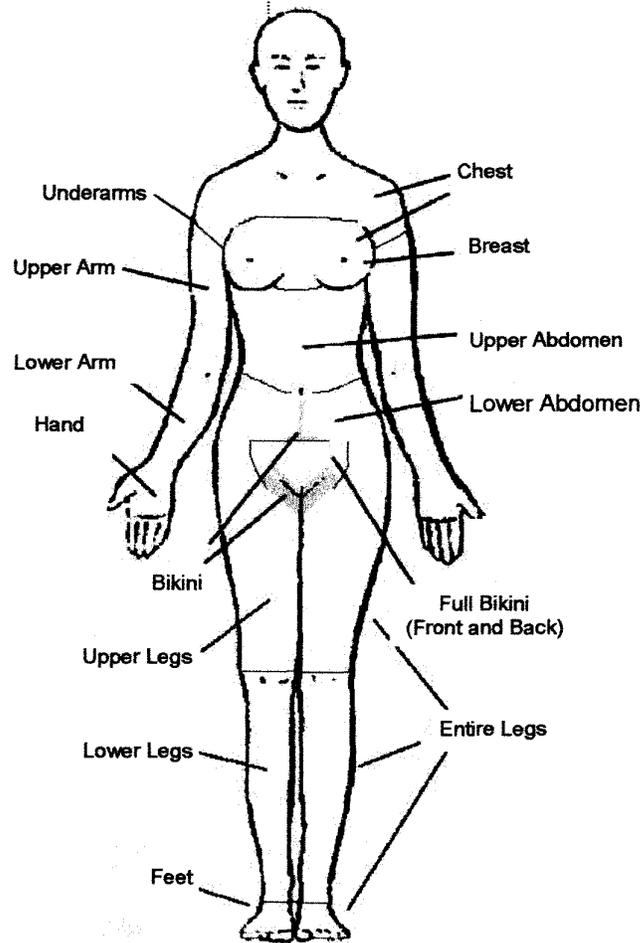
**Lower Legs**=From 1" above the kneecap down to the ankle and it includes feet and toes \_\_\_\_\_

**Lower Abdomen**=Area from the belly button to the top of the bikini line \_\_\_\_\_

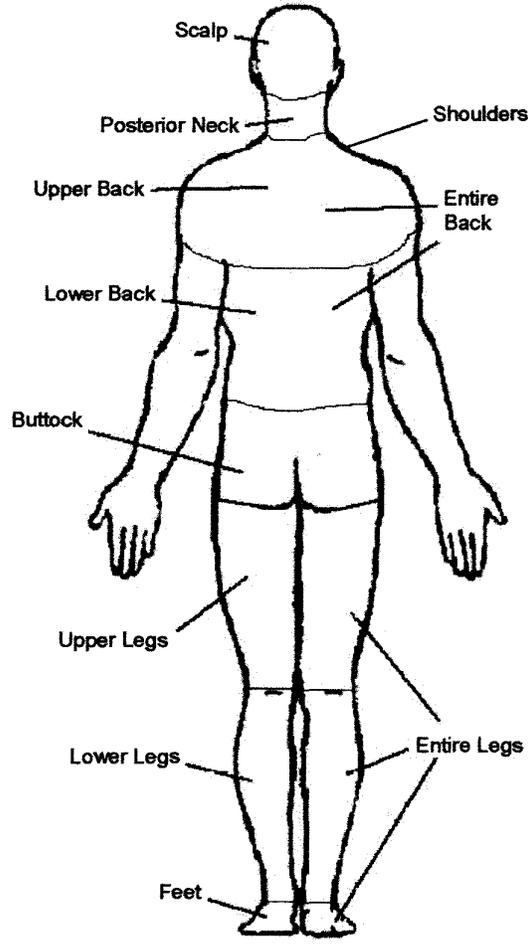
**Upper Abdomen**=Stomach area beneath breasts and above the belly button \_\_\_\_\_

**Breast**=Across the full of the breast and nipples, if the area includes up to the neckline and front of the shoulders, charge for the chest \_\_\_\_\_

**Chest**=From the collarbone to under the pectoral muscles \_\_\_\_\_



<p><b>Scalp</b>=Head from ear to ear, does not include face _____</p> <p><b>Posterior Neck</b>=Back of the neck from the hairline to the collar line. _____</p> <p><b>Entire Back</b>=Starting 1" below the waistline (not the line where low rider pants sit) up to the full of the back, along the sides, if needed, over the tops of the shoulders and natural break at the collarbone, blended down to the bottom of the triceps on the backs of the arms (includes biceps if needed). If area below the triceps is treated price as upper arm. Includes the posterior neck. _____</p> <p><b>Shoulders</b>=3-4 inches across the tops of the shoulders and stops directly on the neckline, blended just over the deltoid. Includes posterior neck, does NOT extend down below the neckline to the upper back. _____</p> <p><b>Upper Back</b>=Starting under the shoulder blades across the upper back area over the shoulders breaking at the collarbone, blended just over the deltoid, includes posterior</p>	<p><b>Lower Back</b>=From the bottom of the shoulder blades down into the waist line and along the sides if needed. _____</p> <p><b>Buttock</b>=From the waistline across the full of the buttock, into the anus area and the seam of the buttock. _____</p> <p><b>Upper Legs</b>=Right above the kneecap and will meet where the bikini line ends 3 inches away from the underwear line and 3 inches away from the seam of the buttocks. _____</p> <p><b>Lower Legs</b>=From 1" above the kneecap down to the ankle and it includes feet and toes. _____</p> <p><b>Entire Legs</b>=Starting at the top of the leg where the bikini area ends down to and including the feet and toes. It does not include the hip or the side of the buttocks. _____</p> <p><b>Feet</b>=From the ankle bone onto the upper foot and toes. _____</p>
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## Spot Test Anatomical Site Sheet Laser Hair Removal

Client Name \_\_\_\_\_ Date \_\_\_\_\_

Client Skin Type \_\_\_\_\_ Laser Used \_\_\_\_\_

Area	Parameters Used	Follicular Responses/Notes:	Pulse Count		Time	Safety Precautions Checklist		Laser Type
			Begin	End	Minutes	Client/Personnel	Room	
1.	HP	<input type="checkbox"/> Excellent <input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor <input type="checkbox"/> Erythema <input type="checkbox"/> Edema				<input type="checkbox"/> Eyewear (755nm) <input type="checkbox"/> Eyes Covered	<input type="checkbox"/> Laser sign on door <input type="checkbox"/> Window covered <input type="checkbox"/> Fire extinguisher	
	Jcm <sup>2</sup>							
	Ms							
2.	HP	<input type="checkbox"/> Excellent <input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor <input type="checkbox"/> Erythema <input type="checkbox"/> Edema				<input type="checkbox"/> Eyewear (755nm) <input type="checkbox"/> Eyes Covered	<input type="checkbox"/> Laser sign on door <input type="checkbox"/> Window covered <input type="checkbox"/> Fire extinguisher	
	Jcm <sup>2</sup>							
	Ms							
3.	HP	<input type="checkbox"/> Excellent <input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor <input type="checkbox"/> Erythema <input type="checkbox"/> Edema				<input type="checkbox"/> Eyewear (755nm) <input type="checkbox"/> Eyes Covered	<input type="checkbox"/> Laser sign on door <input type="checkbox"/> Window covered <input type="checkbox"/> Fire extinguisher	
	Jcm <sup>2</sup>							
	Ms							
4.	HP	<input type="checkbox"/> Excellent <input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor <input type="checkbox"/> Erythema <input type="checkbox"/> Edema				<input type="checkbox"/> Eyewear (755nm) <input type="checkbox"/> Eyes Covered	<input type="checkbox"/> Laser sign on door <input type="checkbox"/> Window covered <input type="checkbox"/> Fire extinguisher	
	Jcm <sup>2</sup>							
	Ms							

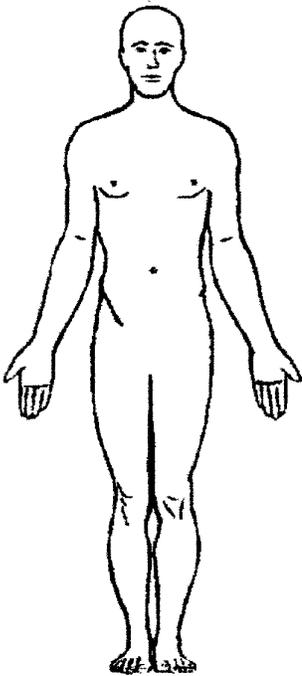
Overall Tolerance Scale 0 1 2 3 4 5  
 Tolerance Key: 0-no pain; 1-mild; 2-tolerable; 3-moderate; 4-uncomfortable; 5-intolerable

Performed by: \_\_\_\_\_

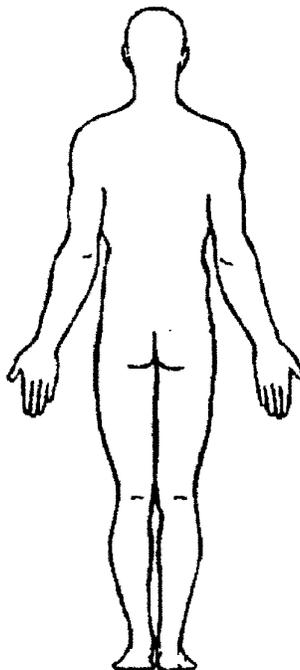
Evaluated by: \_\_\_\_\_  
 Date \_\_\_\_\_

Please write the corresponding number on the area for each test spot treated.

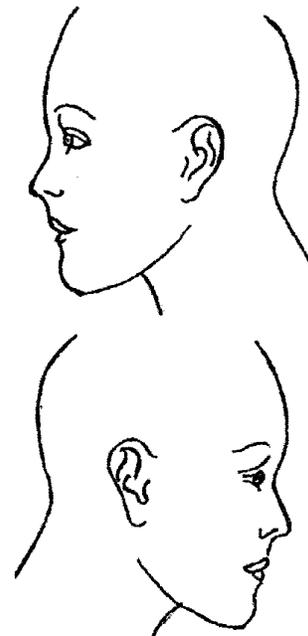
Recommended Settings: \_\_\_\_\_



6-Forms



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Revised April 2008

**Scalp**=Head from ear to ear, does not include face \_\_\_\_\_

**Anterior Neck**=Front of the neck from the jaw line to the hollow of the throat. \_\_\_\_\_

**Chest**=From the collarbone to under the pectoral muscles. \_\_\_\_\_

**Abdomen**=(Men Only) Under the pectoral muscles across the full of the stomach and three inches under the naval if needed. \_\_\_\_\_

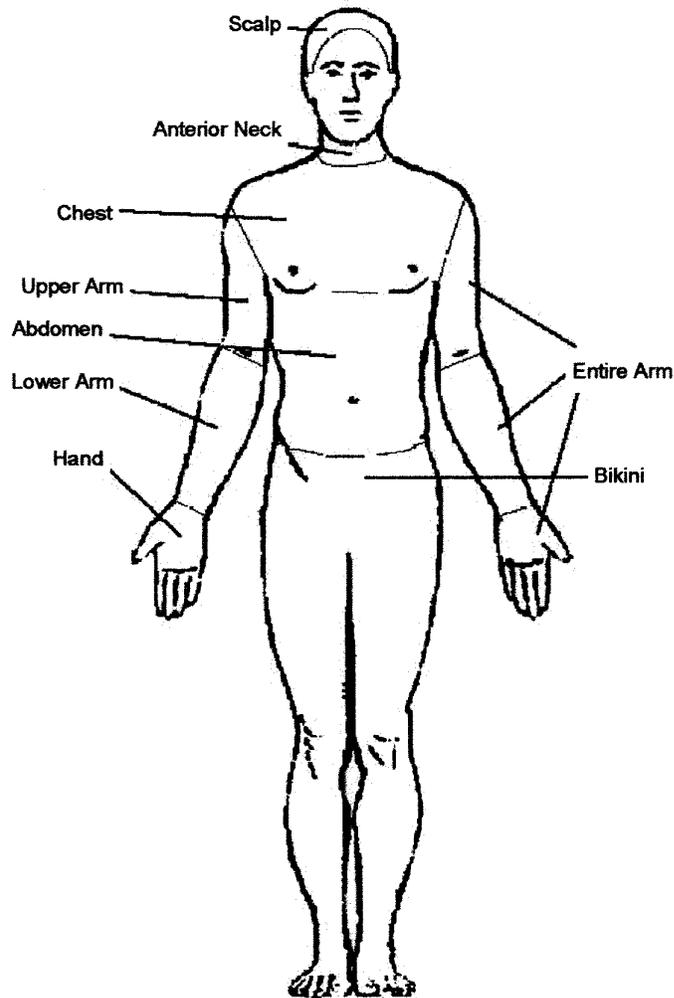
**Upper Arm**=From the elbow to the top of the deltoid, front and back. \_\_\_\_\_

**Lower Arms**=The elbow down to the wrist. Front and back includes the hands. \_\_\_\_\_

**Hands**=From the wrist bones, across the tops of the hands and fingers. \_\_\_\_\_

**Entire Arms**=Upper and lower arms including the hands. \_\_\_\_\_

**Bikini**=3" outside of the underwear line, a half an inch inside the underwear line, and just across the top of the pubic hair. Treatment area does not include anything above the top of the bikini line. \_\_\_\_\_



USE OF PHOTOGRAPHS

EXPLANATION:

This consent form authorizes this clinic and individual members of the clinic's staff to use photographs of pre-treatment, post-treatment, and treatment in progress for the purposes of teaching, research and as illustrations of typical expected results. Under no circumstances will any publication or material bear any name or personal identifier. Your refusal to consent to use these photographs for purposes other than medical record documentation will in no way influence your treatment.

CONSENT:

I understand the photographs taken of me shall be used for documentation in my medical record and if in the judgment of the medical health care professional, medical research, education or science will be benefited by their use, such photographs and information relating to my case may be published and republished, either separately or in conjunction with each other. In professional journals or medical books, or used for any other purpose which my health care professional may deem proper in the interest of medical education, knowledge or research.

I waive the rights that I may have to any claims for payment or royalties in connection with any exhibition, televising or publication of these photographs.

I release and hold harmless the clinic, staff and consultants from any liability in connection with the use of such materials.

I understand that the foregoing consent is subject to the limitation: Under No circumstances will any such publication, film photograph, video or material exhibited contain my name unless voluntarily disclosed by me.

\_\_\_\_\_  
Signature of Patient

\_\_\_\_\_  
Signature of Witness

\_\_\_\_\_  
Printed Name of Patient

\_\_\_\_\_  
Printed Name of Witness

\_\_\_\_\_  
Date

\_\_\_\_\_  
Date