

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

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:_____



Capital Medical Group

Capital Aesthetics

Informed Consent Removal of Pigmented Lesions and/or Spider Veins

Name: _____ Date: _____

I authorize _____, to perform the procedure. The laser system may dramatically reduce darkly pigmented sunspots and spider veins. More than one laser session may be necessary to achieve desired results. However, other treatments, including skin care products, are often needed to blend color, reduce sun damage, and give the best results.

We are unable to treat clients that are on ACCUTANE and PHOTSENSITIZING medications. Clients using ANTICOAGULANTS should be noted.

The following problems may occur with treatment:

1. I understand this treatment is a cosmetic treatment and that no medical claims are expressed or implied.
2. I understand that although uncommon, complications can occur. These complications include local infection, pigmentation changes, scarring, redness, swelling, tenderness, and temporary worsening of the appearance of my veins. I understand that many of these complications are temporary, however I acknowledge that although uncommon the pigmentation changes and scarring can be permanent.
3. I understand there are no guarantees implied as to the results of this treatment, due to many variables, such as age, skin type, skin condition, sun damage, smoking, alcohol, environmental exposures, etc.
4. I acknowledge that I have been candid in revealing any condition which might have an effect on this treatment, such as: pregnancy, medications, previous or recent skin surgery or treatment, skin cancer, cold sores/fever blisters, allergies, use of Retin-A, Accutane, Differin or hormones.
5. I understand that direct sun exposure is prohibited while I am undergoing treatment. The use of sunblock protection with a minimum SPF of 30 is recommended. I agree to refrain from skin tanning in tanning booths while I am undergoing treatment, and during the 14 days following my last treatment.
6. If I am prone to Herpetic outbreaks around the mouth, I have been advised to see my physician for a prescription for Acyclovir or Zovirax.
7. I agree to refrain from any skin care treatment, cosmetic or medical, 14 days preceding and 14 days following any treatment, including filler injections and BOTOX® Cosmetic treatments.
8. I understand that I will not be allowed to have treatments during any pregnancy. My unused treatment fees will be refunded or the unused portion will be placed on hold.

9. Compliance with the aftercare guidelines is crucial for healing, prevention of scarring, hyper-pigmentation and hypo-pigmentation.

I have read and understand this agreement and all my questions have been addressed and answered to my satisfaction. I consent to the terms of this agreement.

Client Name: _____

Signature: _____

Witness: _____

Date: _____

I, the undersigned medical professional, hereby certify that I have reviewed the foregoing treatment consent with the named patient (including the risks of and alternatives to treatment) on or prior to the first date of treatment and have given the patient the opportunity to ask questions regarding his or her treatment, including the opportunity to communicate with a physician.

Medical Professional: _____

Date: _____

 Capital Medical Group
Capital Aesthetics

Pre-Treatment Instructions
Vein Laser Treatments
Client Handout

- ☑ Please try to minimize tanning for a week or two before treatment: a fresh tan can interfere a bit with the effectiveness of the laser/pulsed light treatment, though this is less of a problem with the newer long wavelength lasers, than with older, short wavelength lasers.
- ☑ Please do not wear makeup on the areas to be treated, or at least wear makeup that is easy to remove before treatment so that we can easily see all the vessels you would like to get rid of. If makeup absorbs laser energy, less energy will reach your unwanted blood vessels, and if the makeup heats up it could irritate or burn your skin. Makeup can be re-applied immediately after laser treatment, very gently, if you wish.
- ☑ Please shave or clip the areas to be treated the day before treatment or on the morning of treatment. This way, the skin will be less sensitive. Excess hair above the surface of the skin absorbs and wastes laser energy, and reduces the amount of energy that reaches the unwanted blood vessels where it is really needed. Excess hair above the surface of the skin also increases the chance of burning or irritating the skin. We prefer you shave 24 hours before, but at the very least try and shave a minimum of 4 hours before the laser sessions.
- ☑ Some people find it helpful to take two or three plain Tylenol 2 hours before coming in for treatment. Some women who find that they are less sensitive after their menses prefer to schedule their treatment sessions to avoid the premenstrual and menstrual time. You will be less sensitive if you are well rested, well fed, and not thirsty when you have your treatment. You should pamper yourself on laser days!
- ☑ During the treatment, remember that: “We want to be doing this FOR you, not doing it TO you.” Unexpected discomfort is Nature’s way of telling us something is wrong, so please tell us and we will go slower, apply more cooling, or adjust the power of the laser for you.



Capital Aesthetics

Post-Treatment Instructions

Vein Laser Treatments

Client Handout

- ☑ Redness often has faded greatly within a day or two. It would not be uncommon for the skin to be slightly drier that evening and to require more of your favorite moisturizer or aloe vera cream or lotion. The treated blood vessels may appear slightly more obvious for the next week or two, but this is seldom and a cosmetic problem, and generally much less obvious than after injection sclerotherapy. Masking or concealer cosmetics may be used as necessary, but do not overly rub or irritate the vessels that have been treated.
- ☑ Try to avoid tanning for a week or two after treatment, because occasionally the tan could be somewhat irregular (lighter and/or darker in the treated areas.) and sunscreens are always smart options to protect your skin.
- ☑ You do not need to purchase expensive support stockings or special creams, and there is no special routine for you to follow, except if larger vessels are also treated by sclerotherapy with combination treatments with lasers, then you may be encouraged to wear support hose for several weeks.
- ☑ Blistering or scaling after laser treatments with longer wavelengths of light for removal of blood vessels is very rare, but usually resolves over a few days or a week with a bit of Polysporin or aloe vera cream several times a day. Please call us if you feel you are having any unusual reactions, or if you have any other problems or questions.

502.875.0872

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

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