LASER / IPL CONSULTATION FORM

Surname ______________________ First Name ______________________

Mr/Mrs/Miss/Other ______________________ DOB ___/____/_____

Home Address ____

______________________ Postcode ______________________

Home Tel No ______________________ Mobile Tel No ______________________

Email ____

Emergency Contact Name & Phone Number ______________________________

Ethnic origin ______________________ Occupation ______________________

Treatment Requested (please circle)

Hair Removal / Skin Rejuvenation / Vascular / Pigmentation / Acne /

Tattoo Removal / Fractional Laser / illumiFacial

Other ______________________ Body Area(s) ______________________

Lifestyle & Medical History – **PLEASE TICK OR CROSS** in the box as appropriate. If you do not understand or recognise the condition then please discuss with your laser/IPL operator

Pregnant (or planning pregnancy)	☐	PCOS/hormonal imbalance	☐
Sun tanned/using sun beds or fake tan	☐	Thyroid condition	☐
Skin pigmentation disorders (e.g. melasma, vitiligo)	☐	Regular smoker	☐
History of cancer (or chemo/radio therapy)	☐	Psoriasis/eczema	☐
Diabetes	☐	Depression/anxiety	☐
Epilepsy	☐	Herpes (shingles/cold sores)	☐
Lymphatic/immune system disorders	☐	High blood pressure	☐
History of keloid formation/scarring	☐	Photosensitive conditions	☐
Lupus	☐	Allergies	______________
Communicable diseases (hepatitis/HIV)	☐	Units alcohol/week	______________

Useful comments ____

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Treatment Assessment (to be completed by the operator)

Hair Removal Assessment (please circle)

Hair colour Black Dark Brown Light Brown Red Blonde Grey/White

Hair texture Coarse Medium Fine

Handpiece Selection 650 650 Advance Nd:YAG Alexandrite Diode

Previous/current treatments ____________________

____

Vascular Assessment

Type (please circle) Rosacea Thread veins Spider Nevi PWS Leg veins Other

Previous/current treatments ____________________

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Pigmentation Assessment

Type (please circle) Lentigines (liver spots) Freckles Birthmark (Q-Switch Laser only)

Previous/current treatments ____________________

Acne Assessment

Type (please circle) Mild Moderate Severe

Previous/current treatments ____________________

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Skin Rejuvenation Assessment (please circle)

Type Fine Lines Sun damage Poikiloderma of Civatte Enlarged Pores

Handpiece Selection 650 585 Nd:YAG illumiFacial

Previous/current treatments ____________________

Tattoo Assessment

Colour Black Red/Orange Green Yellow/White Blue Other ____________________

Type Professional Amateur Cosmetic Traumatic Temporary

Comment ____________________

____

Fractional Laser Assessment

Indication (please circle)

General Ageing Wrinkle Reduction Acne/Acne Scarring Scar Pigmentation Other

Comment ____________________

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Are you:

Currently taking any medication or any supplements?

No/Yes (please specify the condition & medications) ______________________________

____

Currently using/used in the last 6 months, any of the following? (please circle):

St John's Wort / Amiodarone / Minocycline / Anticoagulants

Gold Medications / Oral or Topical Retinoids (e.g Roaccutane or Retin A) / Oral or Topical Steroids

Comments: ______________________________

Recovering from any major medical treatment or photodynamic therapy (PDT) within the last 6 months?

No/Yes (please specify) ______________________________

Does the area for treatment have: (please circle)

Moles / Birthmarks / Tattoos / Permanent makeup / Chemical peel / Botox / Injectable fillers / Tanning Injections or Enhancers

____

Skin disorder/disease? No/Yes ______________________________

Had previous Laser or IPL treatment? No/Yes ______________________________

Your skin:

What products do you use on your skin? ______________________________

Please INDICATE how your skin responds to midday summer sun exposure with no sunscreen:

- ☐ Skin Type 1 Always burns, never tans
- ☐ Skin Type 2 Easily burnt, eventually gets a moderate tan
- ☐ Skin Type 3 Sometimes burns, quickly gets an average tan
- ☐ Skin Type 4 Rarely burns, quickly gets a deep tan
- ☐ Skin Type 5 Very rarely burns, consistent tan
- ☐ Skin Type 6 Never burns, consistent tan

Do you currently have a real or fake tan? Yes/ No ______________________________

How long ago was your last UV exposure? ______________________________

Have you ever used tanning injections/enhancers/Melanotan? Yes/No ______________________________

What are your goals/expectations for the treatment?

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Where did you hear about the clinic? Recommendation/Advert/Leaflet/Press/Other ______________________________

Pre Treatment Check List

To be completed by the operator (TICK to confirm points have been discussed)

- ☐ How treatment works
- ☐ Pre/Post treatment care
- ☐ Light Soothe/Light Protect recommended
- ☐ Typical no. of treatments/interval
- ☐ Likely clinical outcome
- ☐ Sensation during treatment
- ☐ Possible side effects
- ☐ Cost per treatment __________
- ☐ Photograph taken

Any further questions / Comments ____

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Informed Consent for IPL/Laser Treatment

Please read this consent form and TICK each box to indicate you understand and accept the information contained herein.

☐ The information I have given is correct to the best of my knowledge, and I have not withheld any known medical state or condition. I will inform the IPL/Laser operator before treatment if there has been any change (for example in medications taken).

☐ I understand that the results from this treatment vary considerably and a small percentage of people will not respond satisfactorily to treatment.

☐ I understand multiple treatments are necessary to achieve satisfactory results.

☐ I understand there is no guarantee of permanent results and maintenance treatments may be necessary.

☐ I understand that I must avoid sun exposure on the treated area for the duration of the treatment (and for up to 1 month afterwards) or use a high sun protection factor to avoid sun damage. I understand that tanned skin cannot be treated.

☐ I understand that there may be short-term side effects such as reddening, bruising, swelling, mild burning or blistering, hypo-pigmentation, (lightening of the skin) or hyper-pigmentation, (darkening of the skin), as well as rare side effects such as scarring and permanent discolouration.

☐ I understand that pigmented areas caused by sun damage may initially turn darker. This will be followed by 'micro-crusting' of the lesion, after which it should flake away leaving an area without excess pigmentation.

☐ I understand that I must wear protective eye goggles to prevent damage from the light.

☐ I agree that my contact details can be used to be kept updated about special offers and other information about the clinic and its services that might be of interest.

☐ I certify that I have read and understood all the information and my questions have been answered satisfactorily before signing this consent form. I consent to the terms of this agreement.

Client Name ______________________ Client signature ______________________

Operator Signature ______________________ Date ______________________