



RECONSTRUCTIVE & AESTHETIC
SURGEONS, INC.

Laser Hair Removal Health and History

Name: _____ DOB: _____ Age: _____ Gender: F/M
Address: _____ City: _____ State: _____ Zip Code: _____
Home Phone: _____ Work Phone: _____ Cell Phone: _____
Email Address: _____ Occupation: _____

How were you originally referred to Bella Via? (Please circle and add note if applicable)
Dr. Colville Dr. Zavell Website Friend: _____
Other: _____

What areas would you like to have treated? _____

What results would you like to see from your treatment? _____

Have you ever had any prior treatment to the affected area? If yes, approximately how long ago? _____

What medications are you currently taking (including aspirin, vitamins, or herbal supplements): _____

Do you have any allergies to medications? If yes, which ones? _____

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

Do you use chemical sun tanning lotions? _____

When exposed to the sun **without** protection for about 1 hour, you:

____ Always burn, never tan ____ Always burn, sometimes tan ____ Sometimes burn, sometimes tan
____ Always tans ____ Hispanic, Asian, Mediterranean, Middle Eastern ____ African American

Are you pregnant? ____ Y ____ N

Do you have permanent makeup (lip liner, eye liner, etc.)? ____ Y ____ N

Do you wear contact lenses? ____ Y ____ N

Do you take any herbal supplements (St. Johns Wort, etc.)? ____ Y ____ N

Do you have very dry skin? ____ Y ____ N

Do you have any active infections? ____ Y ____ N

Do you have a history of keloid scarring? ____ Y ____ N

Do you have any known history of hormonal or endocrine disorders, such as: polycystic ovary syndrome, diabetes, etc,
that may not be under control? ____ Y ____ N

Do you have any known history of Immunosuppressive diseases, including AIDS and or HIV infection, or do you use any
immunosuppressive medications? ____ Y ____ N

Do you have a current history of cancer, especially malignant melanoma, recurrent non-melanoma skin cancer, or pre-
cancerous lesions such as dysplastic nevi? ____ Y ____ N

Do you have a history of bleeding coagulopathies or use blood thinners? ____ Y ____ N

Do you have any diseases which may be stimulated by light, such as: cold sores (Herpes Simplex), Systemic Lupus
Erythematosus, etc.? ____ Y ____ N



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One of the most important factors for the success of your treatment is the correct typing of your skin. Skin type is often categorized according to your genetic disposition, reaction to sun exposure, and tanning habits. Please answer the following questions below to help us determine your correct skin type.

Genetic Disposition:

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

Total Score for **Genetic Disposition** _____

Reaction to Sun Exposure:

| Score | 0 | 1 | 2 | 3 | 4 |
|------------------------------------------------------------|---------------------------------------|--------------------------------|-------------------------------------|----------------|---------------------|
| What happens when you are in the sun for too long? | Painful, redness, blistering, peeling | Blistering followed by peeling | Burns sometimes followed by peeling | Rarely burn | Never burn |
| To what degree do you tan (turn brown)? | Hardly or not at all | Light color tan | Reasonable tan | Tan very easy | Turn 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 |

Total Score for **Reaction to Sun Exposure** _____

Tanning Habits:

| Score | 0 | 1 | 2 | 3 | 4 |
|--------------------------------------------------------------------------------------------|------------------------|----------------|----------------|-----------------------|-----------------------|
| When did you last expose your skin to the sun? (Include tanning booths and/or self tanner) | More than 3 months ago | 2-3 months ago | 1-2 months ago | Less than a month ago | Less than 2 weeks ago |
| Did you expose the area to be treated to the sun? | Never | Hardly ever | Sometimes | Often | Always |

Total score for **Tanning Habits** _____

Add up the total scores for each of the three sections for your Skin Type Score.

Fitzpatrick Skin Type Scale:

| | |
|---------|-----------|
| 0-7 | Type I |
| 8-16 | Type II |
| 17-25 | Type III |
| 26-30 | Type IV |
| Over 30 | Type V-VI |



Consent for Laser Treatment

Thank you for choosing Bella Via Skin and Body Therapies and Reconstructive & Aesthetic Surgeons, Inc. In our ongoing efforts to provide you with the best possible services, we ask that you carefully review this consent form and ask all questions necessary to help you fully understand it. Please sign after careful review.

I understand that the purpose and use of the Lumenis LightSheer™ Diode Laser is intended for permanent hair reduction. The clinical results may vary due to skin type, patient tolerance, individual response to treatment, and patient compliance with pre- and post-treatment instructions.

I understand a single treatment will most likely fail to completely remove all my unwanted hair in the area treated. Multiple treatments are required. Individual response will vary according to skin type, hair color, degree of tanning, follow-up care, and the body area being treated.

Possible Side Effects of Treatment

Discomfort

Some patients experience various degrees of discomfort. Some have described the sensation as stinging, while others have described as similar to a rubber band snap.

Erythema

The most common side effects are erythema (redness) and mild edema (swelling), which generally occur immediately after laser treatments and typically resolve within 24 to 48 hours.

Change of Pigmentation

There may be a change of pigmentation in the treated area. Most cases of hypo- (lighter) or hyper- (darker) pigmentation occur in people with darker skin, or when the treated area has been exposed to sunlight before or after treatment. In some patients, hyper-pigmentation occurs despite protection from the sun. This discoloration usually fades in three to six months, but in rare cases, mainly with hypo-pigmentation, the change may last longer or be permanent.

Blister

In some cases, a crust or blister may form, which may take five to ten days to heal.

Bruising

In some patients, a bruise may appear in the treated area. It may last anywhere between five to fifteen days.

Please Initial the Following:

_____ I understand that there is a possibility of rare side effects such as scarring and permanent discoloration, as well as short-term side effects such as redness, mild burning, bruising, blistering, and temporary discoloration of the skin.

_____ I understand that I am to avoid active sun exposure for 2-4 weeks prior to treatment. I am not actively tanning outside or in a tanning facility at this time.

_____ I will disclose a full and accurate personal medical history to include any and all information regarding medical conditions and my use of medications, drugs, herbs, vitamins, or other supplements of any kind. I understand that failure to do so may affect my treatment outcome.

_____ I understand that photographs may be taken to document treatment results. These photographs **may**_____ or **may not**_____ (please initial one) be used anonymously on our website or in our brochure for advertising purposes.

_____ I understand a patch test must be done before treatment and I must wait three to seven days to observe test before further treatment will be done.



Cancellation Policy

We respectfully request that all of our patients arrive 15 minutes early for their appointment. This will allow you to complete any necessary paperwork required by our staff. Additionally, we appreciate your observance of our 24-hour cancellation policy. This policy allows us time to inform other clients of availability. If you are late for your appointment, we may need to reschedule so that we may properly maintain the nurses' schedules. Thank you for your cooperation in this matter and your consideration for your fellow clients.

Safety

All recommended and required laser safety precautions and all equipment specific guidelines will be followed to ensure the utmost in safety during your treatments. This includes the use of protective eyewear at all times while the laser is in use.

Guarantee

I understand that no specific guarantees are implied or made by this consent form.

I certify that I am a competent adult of at least 18 years of age. Or, that I am a minor under the age of 18 and understand the consent of my parent or legal guardian or person having legal custody of me will also be required prior to the time of treatment. This informed consent is freely and voluntarily executed and shall be binding upon my legal representatives, administrators, successors and assigns.

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

Procedure: _____ Price: _____

My signature below constitutes my acknowledgement and understanding of the information detailed in this form.

Patient Name: _____ Date: _____

Patient or Legal Guardian Signature: _____ Date: _____

Relationship of Legal Guardian to Patient: _____

Witness Signature: _____ Date: _____

