SOLARIS
Laser & Skin Care

`MEDICAL HISTORY FORM

Last Name: _____ First Name: _____
Address: _____
City: _____ State: _____ Zip Code: _____
Telephone: Home: _____ Work: _____ Cell: _____
Date of Birth: _____ Sex: Female _____ Male _____
Family Doctor: _____ Phone: _____
Pharmacy: _____ Phone: _____
Emergency Contact: _____ Phone: _____
Email address: _____
How did you hear about us: _____

Which body area/areas or condition would you like treated? _____
_____
_____

Please answer all of the following questions	**YES**	**NO**
➢ Do you have **ANY** current or chronic medical illnesses? *Disclose any history of heat urticaria, diabetes, autoimmune disorders or any immunosuppression, blood disorders, cancer, bacterial or viral infections, medical conditions that significantly compromise the healing response, skin photosensitivity disorders, or any other condition or illness.* Please List: _____	☐	☐
➢ Do you have **ANY** current or chronic skin conditions? *Also disclose any history of vitiligo, eczema, melasma, psoriasis, allergic dermatitis, any diseases affecting collagen including Ehlers-Danlos syndrome, scleroderma, skin cancer, or any other skin condition.* Please List: _____	☐	☐
➢ Are you currently under a doctor's care? If so, for what reason? _____	☐	☐
➢ Do you take/use **ANY** medications (prescriptions and non-prescriptions), vitamins, herbal or natural supplements, on a regular or daily basis? Please List: _____	☐	☐
➢ Are there any topical products (both medical and non-medical) that you use on your skin on a regular or daily basis? Please List: _____	☐	☐
➢ Do you take/use ANY systemic/oral steroids (e.g., prednisone, dexamethasone)?	☐	☐
➢ Do you have **ANY** allergies to medications, foods, latex or other substances? Please List: _____	☐	☐
➢ (For women) are you or could you be pregnant?	☐	☐
➢ (For women) are menstrual periods regular, or have you ever been diagnosed with Polycystic Ovarian Disorder or a menstrual dysfunction?	☐	☐
➢ Do you have a history of herpes I or II in the area to be treated?	☐	☐
➢ Do you have a history of keloid scarring or hypertrophic scar formation?	☐	☐
➢ Do you have a history of light induced seizures?	☐	☐

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MEDICAL HISTORY, CONTINUED **YES** **NO**

- Do you have any open sores or lesions? ☐ ☐
- Do you have any history of radiation therapy in the area to be treated? ☐ ☐
- In the last six (6) months, have you used any of the following: anticoagulants or blood-thinning medications; photosensitizing medications; or anti-inflammatory or blood thinning medications? ☐ ☐

Please List product name and date last used: _____
_____

- In the last three (3) months, have you used any of the following products: glycolic acid, other alpha hydroxy, or beta hydroxy acid products? ☐ ☐
  Any exfoliating or resurfacing products or treatments? ☐ ☐

Please List product name and date last used: _____
_____

- Do you have or have you ever had any permanent make-up, tattoos, implants, or dermal fillers, including, but not limited to, collagen, autologous fat, Restylane®, etc.? ☐ ☐

If yes, please list locations on or in the body and dates: _____
_____

- Do you have or have you ever had any Botulinums, such as Botox® or Dysport®? ☐ ☐

If yes, please list locations on or in the body and dates: _____
_____

- Have you taken Accutane® (or products containing isotretinoin) in the last 12 months? ☐ ☐
- Have you taken Tretinoin (like Retin-A®, Renova®) in the last 6 months? ☐ ☐
- Have you had any unprotected sun exposure, used tanning creams (including sunless tanning lotions) or tanning beds or lamps in the last 4-6 weeks? ☐ ☐
- Have you been diagnosed with diabetes? ☐ ☐

Signature:_____Date:_____

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Scheduling Policy

Due to the popularity of our services, we have found it necessary to implement the following policy regarding the scheduling of appointments. Once scheduled all appointments require a minimum of 24-hour notice for cancellation.

Failure to follow this policy will result in the following:

Missing 1 appointment without notice: $ 25.00 Charge.
Missing 2 appointments without notice: $ 50.00 Charge.
Missing 3 appointments without notice: $ 75.00 Charge.
No future appointments will be honored until the above fees are paid.

Credit Card information will be collected in registration and will be used **only** for missing appointments.

For Complimentary and Gift Certificate Appointments:

Missing ANY complimentary appointment without a 24-hour notice will result in Complete Forfeiture of the appointment.
Gift Certificates are subject to the same charges as regular appointments.

I have read and fully understand this policy and agree to follow the terms within.

Credit Card Info: **Master Card** ____ **Visa** ____

Card Holder Name: _____ **Card Number:** _____

Expiry Date: _____ **CVS #** _____

SIGNATURE: _____

DATE: _____

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Laser Log

Area Of Treatment	Session 1	Session 2	Session 3	Session 4	Session 5	Session 6	Settings
Date							
Forehead							
Side Burns							
Under Eyes							
Upper Lip							
Chin							
Ears							
Cheeks							
Full Face							
Anterior Neck							
Posterior Neck							
Shoulders							
Under Arms							
Upper Arms							
Fore Arms							
Fingers							
Chest							
Nipples							
Abdomen							
Upper Back							
Lower Back							
Buttocks							
Partial Bikini							
Full Bikini							
Thighs							
Lower Legs							
Feet							
Comments							

513 West Maple Ave West, Vienna, VA 22180 703 255.0300

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VECTUS LASER TREATMENT CONSENT FOR LASER TREATMENT

I authorize **Solaris Laser & skin care LLc.** to perform laser skin treatments on me, including, but not limited to, reducing or eliminating hair, the treatment of pigmented lesions (for example, sun spots, age spots, and other skin discolorations) and vascular lesions (for example, red spots, leg veins and small spider veins, but not for varicose veins). I understand that the procedure is elective, that the results may vary with each individual, and multiple treatments may be necessary.

I understand that:

- The Palomar Vectus Laser is a laser system that delivers a precise pulse of light energy that is absorbed by a chromophore in skin, for example, melanin in hair or pigment in a lesion, causing a thermal reaction. All personnel in the treatment room, including me, must wear protective eyewear to prevent eye damage from this light energy.

- The sensation of light is sometimes uncomfortable and may feel like a moderate to severe pinprick or flash of heat. If the practitioner or physician elect to use an anesthetic to reduce discomfort during any light based treatment, all options and risks associated with the anesthetic will be discussed with me.

- The treated area may be red and swollen for two to twenty-four (2-24) hours or longer. Cooling the area after the treatment (for example, ice packs, topical gels) may help reduce discomfort and swelling.

- Common side effects include temporary redness (erythema) or mild "sunburn"-like effect that may last a few hours to 3-4 days or longer. Other potential side effects include, but are not limited to, crusting, irritation, peeling, bruising, redness, ingrown hairs, itching, pain, burns, scabbing, swelling (edema), broken capillaries, bronzing, and acne or herpetic breakouts. There also is a risk of resulting unsatisfactory appearance and failure to achieve the desired result.

- Pigment changes, including hypo pigmentation (lightening of the skin) or hyper-pigmentation (darkening of the skin) lasting one to six (1-6) months or longer or permanently may occur. Freckles may temporarily or permanently lighten or disappear in treated areas.

- Lightening or darkening of vascular lesions may occur.

- Serious complications are rare but possible, such as, scarring, blood clots, skin loss, hematomas (collection of blood under the skin), and allergic reaction to medications or materials used during the procedure.

- I understand and accept that there is a chance of additional side effects like blanching and significant redness.

- There is no guarantee that the expected and anticipated results may be achieved.

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- Sun, tanning bed, or tanning lamp exposure, the use of self-tanning creams, and not adhering to the post-treatment instructions provided to me may increase my chance of complications. I must avoid the sun, tanning beds and sunless tanning lotions and use sunblock (SPF 45 recommended) after treatment.

- There is a possibility of coincidental hair removal when treating pigmented or vascular lesions in hair bearing areas. There is a risk that the hair regrowth may be changed, such as little or no regrowth or more regrowth than before.

- There is a high risk of paradoxical hair growth in people of Middle Eastern and Mediterranean descent and those who have an ill-defined hair line with no obvious transition of the hairline to the face.

- I should call my provider as soon as possible if I have any concerns about side effects or complications after treatment.

- I hearby consent to the administration of any anesthesia or sedation considered necessary or advisable for my procedure(s). I understand that all forms of anesthesia and sedation involve risk and the possibility of complications, injury, and in rare instances death.

- Not providing my medical history before proceeding with a light based treatment could impact treatment results and cause complications.

I consent to photographs and digital images being taken and used to evaluate treatment effectiveness, for medical education, training, professional publications or sales purposes. No photographs or digital images revealing my identity will be used without my written consent. If my identity is not revealed, these photographs and digital images may be used, shared, and displayed publicly without my permission.

YES NO

Before and after treatment instructions have been discussed with me. The procedure, potential benefits and risks and alternative treatment options have been explained to my satisfaction.

I have read and understand all information presented to me before agreeing and authorizing treatment. I have had all my questions answered.

I freely consent to the proposed treatment today as well as for future treatments as needed.

Signature: _____ Date: _____

Printed name: _____

Witness Signature: _____ Date:_____