



Laser Lisse, LLC

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INITIAL ASSESMENT FORM

Today's Date: _____

Please fill out items below:

Full Name: _____

Home Address: _____

Phone : Cell / Home _____ Email Address: _____

Who Referred You? _____

Desired treatment: _____

Check one: **NO / YES** **COMMENTS**

- 1. Are you pregnant or nursing?
- 2. Do you have a known hernia (or diastasis) in the area to be treated?
- 3. Have you tanned or done a self-tanner within the last 2 weeks?
- 4. Have you been on Accutane (Isotretinoin) within the last 6 months?
- 5. Have you had facial laser resurfacing and deep chemical peeling within the last 3 months?
- 6. Have you been on antibiotics within the last 10 days?
- 7. Are you currently undergoing treatment for cancer?
- 8. Do you have a condition that makes you sensitive to sunlight? (lupus, Porphyria)
- 9. Do You have dry, fragile skin?
- 10. Have you used any topical tretinoin (Retin-A) within the last week?
- 11. Have you had any metal or other implants / injectables / permanent make-up /tattoos ?
- 12. Do you have a history of keloids or abnormal scaring?
- 13. Do you have a history of skin cancer or any other cancer?
- 14. Do you have a Pacemaker or internal defibrillator?
- 15. Do you have a serious medical condition (*heart disease or uncontrolled diabetes*)?
- 16. Do you have a history of Herpes /Cold sores ?

List your **Allergies:** _____

List your **Medications and Dosages:** _____

List **Medical Conditions** and surgeries:

Previous Laser or Fat destruction Treatment (specify date/number of treatments/ frequency/tissue response and device used if known):

Previous Hair Removal History (if applicable) i.e. **waxing | bleaching | shaving | tweezing | electrolysis**):

Please list the frequency and the last use of the above modalities: _____

FOR STAFF USE ONLY

Initial Assessment / Plan: _____

_____ **1) Treatment options and benefits of treatment:** _____

_____ **2) Patient expectations:** _____

_____ **3) Full treatment schedule process** _____

_____ **4) Possible side effects (for Laser) hyper / hypopigmentation, purpura, scarring, burns, textural change, blistering, pain or discomfort and erythema. (for UltraShape) redness, discomfort, warmth, vibration.**

_____ **5) Importance of sun expose avoidance and use of zinc or titanium dioxide sunblock 30+**

_____ **6) Cost** _____

_____ **7) Eye wear protection during laser treatments and Laser safety: May sense light during treatment.**

_____ **8) Importance of post care instruction: Review of instructions.** _____

Physician Signature: _____ **Date:** _____ **Photos today? Yes / No**

TREATMENT PLAN: