CONSULTATION FORM

FOR ALL LIGHT BASED PROCEDURES

REVIVE AT THE GROUP

DATE: _____

NAME: _____ AGE: _____

TREATMENT AREA: _____ FITZ. SKIN TYPE: I II III IV V VI

PAST MEDICAL HISTORY: _____

PREGNANT _____ YES _____ NO

CURRENT MEDICATIONS: _____

ALLERGIES: _____

HISTORY:	YES	NO	DATE	INITIAL
ANY ALLERGIES TO RED DYE	☐	☐		
RECENT SUN EXPOSURE	☐	☐		
PREVIOUS LASER TREATMENTS	☐	☐		
HAIR REMOVAL				
WAXING, TWEEZING, ELECTROLYSIS	☐	☐		
MICROBLADING	☐	☐		
ACCUTANE (LAST 6 MONTHS)	☐	☐		
GOLD THERAPY	☐	☐		
COAGULOPATHIES	☐	☐		
DOXYCYCLINE / BLOOD THINNERS	☐	☐		
HERPES / COLD SORES	☐	☐		
VITILIGO	☐	☐		
HISTORY OF MELANOMA	☐	☐		
HIVES	☐	☐		
DIABETES	☐	☐		
KELOIDS/HYPERTROPHIC SCARRING	☐	☐		
TATTOOS/PERMANENT MAKE-UP	☐	☐		
FILLERS, BOTOX, ETC.	☐	☐		
PACEMAKER/DEFIBRILLATOR	☐	☐		
IMPLANTS/SURGERIES IN TX AREA	☐	☐		
DECREASED SENSATION/NUMBNESS IN TX AREA	☐	☐		

OTHER RECENT ESTHETIC PROCEDURES: _____

WHAT IS YOUR ETHNIC BACKGROUND? _____

HOW WELL DO YOU TAN W/O SUNSCREEN? _____

ARE YOU GOING ANYWHERE THIS WEEKEND? _____

INITIAL	
_____	BENEFITS OF PROCEDURE DISCUSSED
_____	CONTRAINDICATIONS REVIEWED
_____	RISKS REVIEWED
_____	PROBABILITY OF SUCCESS REVIEWED
_____	ALTERNATIVE PROCEDURES AVAILABLE
_____	CONSENT SIGNED
_____	VERBAL AND WRITTEN POST-TREATMENT INSTRUCTIONS GIVEN TO PATIENT
_____	PRE-OP PHOTOS TAKEN
	APPOINTMENT SCHEDULED ON; _____/_____/_____

COMMENTS:

SIGNATURE OF CONSULTANT: _____