FAIRLAWN DERMATOLOGY, LLC

FOR THE LIGHT BASED PROCEDURES

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	N/A	DATE
Recent Sun Exposure				
Previous Laser Treatments				
Hair Removal - Waxing, Plucking, Electrolysis				
Accutane in last 6 months				
Gold Therapy				
Coagulopathies				
Herpes/Cold Sores				
Vitiligo				
History Melanoma				
Keloids/Hypertrophic Scarring				
Tattoos/Permanent Make-up				
Fillers, Botox, etc.				
Pacemaker/Defibrillator				
Implants/Surgeries in treatment area				
Decreased sensation/Numbness in treatment area				

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
_____ Pretreatment photos taken

Comments:

Signature of Consultant: _____