MEDICAL HISTORY

Name:_____ Age:_____

Address:_____City:_____ Postal Code:_____

Home Phone:_____Cell Phone:_____

Email:_____

Referred by:_____

The following information is for internal use only and will be strictly kept private and confidential and used for the documentation process only. Anonymous photos of a specific area of concern may be taken to assist in a clinical audit and education purposes only. Your privacy is very important to us.

Have you ever had the following?

___ Current or history of cancer, especially malignant melanoma or recurrent non-melanoma skin cancer, or precancerous lesions such as multiple dysplastic nevi

___ Any Active infection

___ Diseases which may be stimulated by light, such as history of recurrent herpes simplex, systemic lupus erythematous, or porphyria.

___ Use of photosensitive medication and/or herbs sc. as Isotretinoin, tetracycline, or St John's wort.

___ Use of Accutane within the past 6 months

___ Immunosuppressive diseases, including AIDS and HIV infection, or use of immunosuppressive medications

___ Patient history of hormonal or endocrine disorders, such as polycystic over syndrome or diabetes, unless under control.

___ History of coagulopathy (bleeding disorder), or us of anticoagulants.

___ History of keloid scarring

___ Very dry skin

___ Exposure to sun or artificial tanning during the 3-4 weeks prior to treatment

Are you pregnant?___ Do you wear contact lenses?___ Daily consumption of alcohol _____
What medications are you taking (including aspirin)?_____
Allergies:_____
Are you taking any herbal preparations? (St John's Wort, etc.) ___ If yes, list _____
Skin Type (when exposed to the sun without protection for about 1 hour):_____
___Always burn, never tans
___Always burns, sometimes tans
___sometimes Burns, sometimes tans
___Always tans
___Hispanic, Asian, Mediterranean, Middle Eastern
___Black

When were you last in sun/ tanning bed?_____ Do you use chemical sun tanning lotions?_____
Are you planning a holiday in the sun? _____ when? _____
Reason for visit (area(s) to be treated) _____
Prior treatment (if any): _____

LASER HAIR REMOVAL PATIENT WAIVER and CONSENT

I hereby authorize and direct a Epiphany Spa &Wellness Inc. Laser technician to perform laser assisted hair removal treatments on me. I understand that this procedure works on the active growing hairs and not on dormant hairs. For this reason, complete destruction of a hair follicles from any one treatment is not possible and I understand that I will require several treatments to obtain a significant, long-term reduction of hair growth. I also understand that some people may not experience complete hair loss even with multiple laser treatments.

The following has been discussed with me and I have had the opportunity to ask question:

____ The potential unexpected consequences of the procedure and possible individual reactions.

____ I confirm that I am not pregnant and will notify technician prior to treatments if I become pregnant or if my medical condition or any health related circumstances, including medication, change.

____ Results may vary depending on medical history, natural or induced applicable hormone levels, skin/ hair types, patient compliance with pre/ post treatment instructions.

____ Complete and permanent hair removal is the treatment goal but not guaranteed. Individual results vary.

I am aware that the following possible experiences/risks can occur as a result of the treatment:

___ **DISCOMFORT:** Some discomfort may be experienced during laser treatment.

___ **WOUND HEALING:** Laser hair Treatment can result in swelling, blistering, crusting or flaking of the treated areas, which may require 1-3 weeks to heal. Once the surface has healed, it may be pink or sensitive to the sun for several months or longer in some patients. This is more likely to happen in patients taking medications causing photosensitivity or in patients with dark skin.

___ **EYE EXPOSURE:** Protective eyewear will be provided to wear during the laser treatment. It is MANDATORY that these shields be worn at all time during the treatment. Failure to do so could result in accidental laser exposure to the eye that could cause vision damage.

___ **EVERYONE MAY EXPERIENCE NEW HAIR GROWTH OR RE-GROWTH** over time regardless of the technology used. Hair that grows back will tend to be finer, lighter and less dense.

___ I **ACKNOWLEDGE** the published refund and cancellation policy and agree to provide at least 24 hours notice to reschedule my appointment otherwise I will lose 30% of the paid treatment.

By signing below, I certify that I have read and fully understand the contents of this waiver and give my consent to receive Laser hair Removal treatments and agree.

Client Signature: _____ Date: _____

SOPRANO XL LASER LOG

Date: _____

Patient: _____

Doctor: _____

Laser Operator: _____

Procedure: _____

Fitzpatrick Skin Type: I II III IV V V VI

Medical History completed: ☐ **Yes** ☐ **No**

Laser:

Soprano XL HR _____ Soprano XL SHR _____

Soprano XL SHR Settings:

Joules: _____ Kj's:_____ Hz 10Hz

Soprano XL HR Settings:

Pulse Type: _____ Joules:_____ Hz: _____

NIR:

Watts:_____ Kj's:_____

Laser Safety Checklist followed? ☐ Yes ☐ No If no, explain:

_____

_____

_____

Notes:_____

_____

_____

_____

_____

Signature: _____