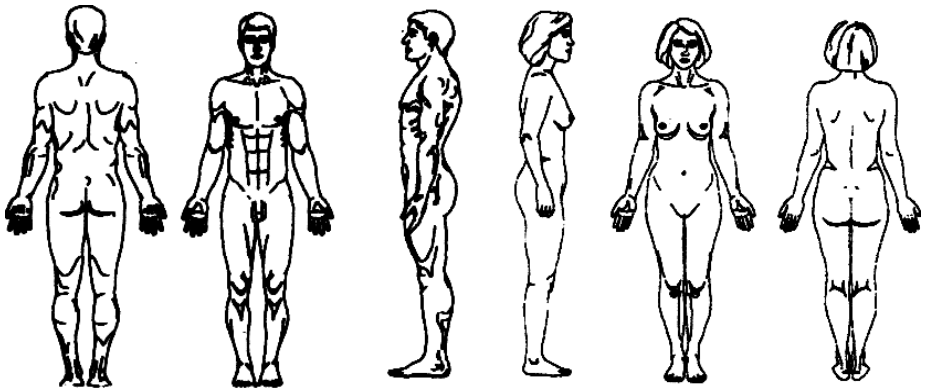
Name _____ DOB_____ DOS_____

CC: Patient Presents for Pigmented Lesion Removal.

| | | |
|---|---|---|
| Age of Lesion | | _____ |
| Problems with pigmentation other than cosmetic objection? | Yes | No |
| Patient experienced any adverse reactions to lasers in the past? | Yes | No |
| Patient pregnant at this time? | Yes | No |
| Patient had abnormal scarring in the past? | Yes | No |
| Patient on any medications that would cause hypersensitivity to the laser? | Yes | No |
| Patient allergic to any medications or other substances? | Yes | No |

| | | |
|---|---|---|
| PE: Patient presents with skin type | | _____ |
| Skin appears to be intact with no erythema, edema, scarring, or lesions. | Yes | No |
| The skin has abnormal pigmentation secondary to undesired pigment. | Yes | No |
| Patient appears to be a good candidate for laser treatment. | Yes | No |

Notes:



Tx: Laser treatment using Astanza Q-Switched lasers to remove pigmentation.

| TREATMENT NUMBER | TREATMENT AREA | WAVELENGTH USED | SPOT SIZE | F J/cm2 | Hz PPS | FEE CHARGED | PAID AMOUNT | BALANCE OWED |
|---|---|---|---|---|---|---|---|---|
| | | | | | | | | |

Post TX: _____

Patient has/has not been given “Pigmented Lesion Treatment Aftercare Instructions” and will notify me if there are any non-emergent questions or concerns and will call 911 in case of an emergency.

RTC: 6 weeks 8 weeks 10 weeks Pigmentation Fully Removed

Certified Laser Specialist _____

EAST HILL
MEDICAL GROUP

**CLIENT INFORMATION & MEDICAL HISTORY**

Please complete the following questionnaire prior to treatment. All information is strictly confidential.

**PERSONAL HISTORY**

Client Name _____ Today's Date _____

Date of Birth_____ Age_____Occupation _____

Home Address_____ City_____ State_____ Zip _____

Home Phone ( _____ ) _____-_____ Cell Phone ( _____ ) _____-_____

Emergency Contact Name and Phone _____

Email_____

How did you hear about us? Please circle one

INTERNET SEARCH (Google / Yahoo / MSN): Search Term Used: _____

OTHER: _____ REFERRED BY: _____

Which of the following best describes your skin type? (Please circle one type number)

| | | | |
|---|---|---|---|
| I | Caucasian, fair skin, light eyes | IV | Mediterranean, Asian, Hispanic |
| II | Caucasian, fair to tan skin, medium eyes | V | Middle Eastern, Latin, Light-skinned African, Indian |
| III | Darker Caucasian, light Asian, Tan complexion | VI | Dark-skinned African |

Which pigmented lesion(s) are you interested in treated today? _____

What area(s) of the body are the pigmented lesion(s):_____

**MEDICAL HISTORY**

Are you currently under the care of a physician? ❑Yes ❑No If yes, for what: _____

Are you currently under the care of a dermatologist? ❑Yes ❑No If yes, for what:_____

Have you ever had a reaction to a previous laser treatment, heat treatment, or radiation therapy? ❑Yes ❑No

Do you have any of the following medical conditions? (Please check all that apply)

❑Cancer ❑Diabetes ❑Herpes ❑Arthritis ❑Frequent cold sores ❑HIV/AIDS ❑Keloid scarring ❑Skin disease/Skin lesions ❑Seizure disorder ❑Hepatitis ❑Blood clotting abnormalities ❑Any active infection

Do you have any other health problems or medical conditions? Please list: _____

**MEDICATIONS**

What oral medications are you presently taking? Please List: _____

Have you ever taken Accutane for acne? ❑Yes ❑No If yes, when did you last use it? _____

What topical medications or creams are you currently using? ❑ Retin-A® ❑Others (Please list): :_____

Have you ever had an allergic reaction to any medication? Please List: _____

**HISTORY**

Do you currently have a sunburn? ❑Yes ❑No

Do you form thick or raised scars from cuts or burns? ❑Yes ❑No

Do you have Hyperpigmentation (darkening of the skin) or Hypopigmentation (lightening of the skin) or marks after physical trauma? ❑Yes ❑No

If yes, please describe: _____

For our female clients: Are you pregnant or trying to become pregnant? ❑Yes ❑No Are you breastfeeding? ❑Yes ❑No

*I certify that the preceding medical, personal and skin history statements are true and correct. I am aware that it is my responsibility to inform the technician, doctor, or nurse of my current medical or health conditions and to update this history. A current medical history is essential for the caregiver to execute appropriate treatment procedures.*

Signature_____ Date:_____

# Informed Consent for Pigmented Lesion Treatment

I, _____, consent to and authorize East Hill Medical Group to perform a number of treatments, laser procedures, and related services on me. The procedure planned uses laser technology for the removal of pigmented lesions.

As a patient you have the right to be informed about your treatment so that you may make the decision whether to proceed for laser treatment or decline after knowing the risks involved. This disclosure is to help to inform you prior to your consent for treatment about the risks, side effects and possible complications related to laser treatments:

The following problems may occur with the laser pigmentation removal process:

1. **The possible risks of the procedure include but are not limited to** pain, swelling, redness, bruising, blistering, crusting/scab formation, ingrown hairs, infection, and unforeseen complications which can last up to many months, years, or permanently.

2. **There is a risk of scarring.** Scarring happens but is uncommon. Scarring can be permanent.

3. **Short-term effects may include reddening, mild burning, temporary bruising, or blistering.** A brownish/red darkening of the skin (known as **hyperpigmention**) or lightening of the skin (known as **hypopigmentation**) may occur at times up to 3-6 months, years, or permanently following treatment. Loss of freckles or pigmented lesions can occur.

4. Textual changes in the skin can occur and can be permanent.

5. **Infection:** Although infection following treatment is unusual, bacterial, fungal, and viral infections can occur. Should any type of skin infection occur, additional treatments, or medical antibiotics may be necessary.

6. **Bleeding:** Pinpoint bleeding is rare but can occur following treatment procedures. Please follow the basic after-care instructions to prevent the risk of infection.

7. I understand that exposure of my eyes to light could harm my vision. I must keep the eye protection goggles on at all times.

8. Compliance with the aftercare guidelines is crucial for healing and the prevention of scarring and skin tone changes.

Occasionally, unforeseen mechanical problems may occur and your appointment will need to be rescheduled. We will make every effort to notify you prior to your arrival to the office. Please be understanding if we cause you any inconvenience. We occasionally may use photographs taken before or after treatments in order to assess, promote, train, or improve our services. These will be used anonymously and only include the treated area and not associated with any particular patient.

ACKNOWLEDGMENT:

My questions regarding the procedure have been answered satisfactorily. I understand the procedure and accept the risks. I hereby release East Hill Medical Group, its staff, and medical director from all liabilities associated with the above indicated procedure.

Client/Guardian Signature_____ Date: _____

Certified Laser Specialist _____ Date: _____

EAST HILL
MEDICAL GROUP
99 S Alcaniz St. Suite B
Pensacola, FL 32505
850-437-0035

# Pigmented & Vascular Lesion Aftercare Instructions

The laser treatment may create sensitive skin or small blisters over the area(s) treated. Some patients may experience bruising or swelling. There is immediate whitening of the treated area, which usually lasts for several minutes. Many clients then develop blisters, crusts, or scabs within 8-72 hours, which may last for 1-2 weeks or more. The treated areas may be pink or pale after the scab separates. Scarring, which can be hypertrophic or even keloid, can occur but is very rare. Loss of skin pigment in the treated area can occur and is temporary except in very rare cases. Healing is usually complete within 4 weeks, although this may vary.

1. Keep the treated area clean and dry while it is healing. Clean the area gently with soap and water and then pat the area dry. You may apply a thin coating of ointment or lotion for the first 2 days following treatment.

2. Blisters are rare but may occur. Do not be alarmed as blisters heal very well and are part of the normal healing process. If small blisters do appear over the treated area, simply apply an ointment and a small bandage while the skin heals.

3. Do not pick at any scabs or allow the skin to become scraped, as this may result in infection and scarring. Shaving should be avoided in the treated area until it is completely healed.

4. Feel free to shower 2 hours after the treatment, but take care to avoid high pressure water hitting the treated area. Baths, hot tubs, swimming pool, or any form of soaking are not recommended until all blistering and scabbing are completely healed as they may increase the risk of infection.

5. Exercise is generally safe after treatment taking into account the other after care instructions provided here.

6. Wear a sun block with an SPF of 25 or higher over the area daily to prevent additional lesions from forming.

7. Makeup may be applied over the treated area if necessary.

8. Itching is very common due to the dehydrating effect of the laser treatment. Use Aquaphor, vitamin E ointment, or hydrocortisone cream to the treatment area.

9. If the area looks infected (honey colored crusting and oozing or spreading redness), if you experience an unusual discomfort or bleeding, if any other complications develop, or if you have any questions or concerns, contact the office immediately.

10. Of course, if you have any extreme reaction, call 911 and go to the emergency department.