Medical Health History and Skin Care Profile

Help us get to know you a little bit better by kindly filling out the information below. Should you have any questions, please let us know and we would be happy to assist.

Title: ☐ Mr. ☐ Mrs. ☐ Ms. First & Last Name: _____

Clinic Name: _____

Email Address: _____

Address: _____ City: _____ Province: _____

Postal/Zip Code: _____ Telephone Number: (_____) _____ Birthday: _____

Occupation: _____ Emergency Contact Name: _____

Emergency Contact Number: _____ Relationship: _____

ALLERGIES and SENSITIVITIES (please list):

_____

SKIN CONDITIONS (select all that apply)

- ☐ Acne: Mild, Moderate, Cystic **(please circle)**
- ☐ Rosacea
- ☐ Acne scars
- ☐ Aging Skin
- ☐ Back/Chest Acne
- ☐ Blackheads
- ☐ Whiteheads
- ☐ Blistering Sunburns (past/present)
- ☐ Burn
- ☐ Cosmetic Product Reaction
- ☐ Dark under-eye circles
- ☐ Dermatitis
- ☐ Dry skin
- ☐ Eczema
- ☐ Elastosis (Sagging skin)
- ☐ Enlarged pores
- ☐ Freckles
- ☐ Herpes Simplex (cold sores)
- ☐ Hyperkeratinisation
- ☐ Hyperpigmentation (age spots)
- ☐ Hypopigmentation (white spots)
- ☐ Keratosis Pilaris (skin bumps)
- ☐ Lines/wrinkles
- ☐ Moles
- ☐ Pseudo Folliculitis Barbae (Ingrown hairs)
- ☐ Psoriasis
- ☐ Salicylic/Aspirin Allergy
- ☐ Scarring (Raised, depressed or flat)
- ☐ Keloid scarring

- ☐ Seborrhea (excessive oiliness)
- ☐ Sensitive skin
- ☐ Aloe Allergy
- ☐ Skin cancer (past/present)
- ☐ Skin discoloration
- ☐ Tattoos
- ☐ Cherry Haemangiomas
- ☐ Stretch marks
- ☐ Sun Damage
- ☐ Telangiectasia
- ☐ Uneven Texture
- ☐ Vitiligo

Please list your top 3 skin care concerns in order of priority:

1. _____

2. _____

3. _____

SUN EXPOSURE

How do you react to the sun?

- ☐ Always burn, never tan
- ☐ Burn first, tan with difficulty
- ☐ Burn first, tan with ease
- ☐ Seldom burn, tan with ease
- ☐ Never burn, always tan

Do you use sun protection?

- ☐ Yes
- ☐ No

Sun Exposure?

- ☐ Occasional
- ☐ Occupational
- ☐ Recreational

When were you last exposed to the sun?

- ☐ Less than a week
- ☐ 2 weeks
- ☐ 1 month

Do you use tanning beds?

- ☐ Yes
- ☐ No

If yes, how often? ☐ Weekly ☐ Monthly ☐ Several times a week ☐ A few times per year

Do you use self tanner?

- ☐ Yes
- ☐ No

COSMETIC MEDICAL HISTORY

Are you under the care of a dermatologist?

- ☐ Yes
- ☐ No

Reason for treatment? _____

Do you currently use, or have you previously used?

- ☐ Accutane
- ☐ Retinol
- ☐ Hormone replacement therapy

If yes, when: _____

Have you had plastic surgery?

- ☐ Yes
- ☐ No

If yes, what procedure: _____ when: _____

Have you had cosmetic injections?

- ☐ Yes
- ☐ No

If yes, what: _____ body part: _____ when: _____

Have you had any of the following cosmetic treatments (select all that apply):

- ☐ Peels
- ☐ Hair Reduction
- ☐ Photo facial
- ☐ Laser Resurfacing
- ☐ Body/Face Contouring
- ☐ Micro-needling
- ☐ Microblading

GENERAL MEDICAL HISTORY

Do you have or ever had skin cancer?

- ☐ Yes
- ☐ No

When: _____ Where: _____ Type: _____

Please list all current medications:

_____

_____

Please list all relevant surgeries and when:

_____

Please select all that apply:

- ☐ Anxiety depression
- ☐ Cancer
- ☐ Constipation
- ☐ Contact lenses
- ☐ Crohn's/IBS
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Pacemaker
- ☐ Arrhythmia or Dysrhythmia
- ☐ Hearing Aids
- ☐ Heart Disease
- ☐ Hepatitis B or C
- ☐ HIV
- ☐ Lupus
- ☐ Arthritis
- ☐ Asthma
- ☐ Implants (metal, silicone)
- ☐ Thyroid disorder
- ☐ Birth control
- ☐ IUD
- ☐ Menopause
- ☐ Pregnant
- ☐ Breastfeeding

LIFESTYLE

Have you had children?

- ☐ Yes
- ☐ No

How would you rate your stress level?

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- ☐ High
- ☐ Moderate
- ☐ Low

On average how much sleep do you get per night?

- ☐ More than 8 hours
- ☐ 6-8 hours
- ☐ Less than 6 hours

How would you rate your diet?

- ☐ Healthy
- ☐ Poor
- ☐ Vegetarian/Vegan
- ☐ Restricted

Please list any dietary supplements or vitamins you are currently taking:

_____

How much of the following do you have each day?

Coffee: _____ Water: _____

Alcohol: _____ Cigarettes: _____

How often do you exercise?

- ☐ Less than 2 days a week
- ☐ 3 days a week
- ☐ More than 5 days a week

A complete and accurate health history is important to ensure that it is safe for you to receive treatment and to determine the treatment and products that are most beneficial. Treatment protocol is based solely on the information provided. By signing below, you understand that the information that you have provided above is the most accurate to your knowledge and will be confidential retained exclusively by Sharplight.

Date: _____ **Signature:** _____

***All patients must sign a consent form before any treatment.**

DPC Consent Form

For Hair Reduction, Skin Rejuvenation, Pigmented lesions, Vascular lesions, and Acne.

Name: _____ Date: _____

I authorize you to perform a Pulsed Light System procedure. I am aware that these treatments are intended to result in hair reduction, skin rejuvenation, or improvement of pigmented and vascular lesions and acne. I understand and accept that it is necessary to conduct more than one treatment in order to achieve results. I also accept that it may be necessary to use other manners of treatments, including skin care products, needed to blend color reduce sun damage and more.

The skin treated will be red and swollen for a period of time, with the forming of fine, thin scabs. Keep the treated areas covered with Aloe Vera gel and soothing creams until the thin scabs fall off. This process will take between 1- 3 weeks. It could take as long as 3-6 months in some rarer cases. Do not scratch the scabs, as scarring may result.

We are unable to treat clients who are taking ACCUTANE and PHOTOSENSITIZING medications.

Client must fill in a medical history form which must be updated if any changes occur during the treatment period.

The following problems may occur with treatment:

1. Scarring: The pulsed light system can create a bruising and a moderate burn or blister to the skin. For an effective treatment, the intensity (joules) must be just below the blistering point which means that the skin will be red (erythema). There is a risk of scarring in burned skin cases.

2. Hyperpigmentation and hypopigmentation have been noted to occur after treatments, especially with a darker complexion. This usually resolves within weeks, but it can take as long as 3-6 months in some cases. Permanent color change is a rare risk. If you have dark skin, a skin lightening cream may be advised to reduce the melanin in your skin before the treatment. Avoiding sun exposure before and after the treatment is crucial to reduce the risk of color change and burns.

3. Infection: Although infection following pulsed light treatment is unusual, bacterial, fungal, and viral infections can occur. Herpes simplex virus infections around the mouth can occur following a treatment. This applies to individuals with a past history of Herpes simplex virus infections in the area. Should any type of skin infection occur, additional treatment including antibiotics will be necessary.

If you have a history of Herpes simplex virus in the treated area, we recommend preventive therapy.

4. Bleeding: Pinpoint bleeding is rare but can occur following pigmented and vascular lesion treatment procedures. Should bleeding occur, additional treatment might be necessary.

5. Skin tissue pathology: Energy directed at skin lesions may potentially vaporize the lesion. Laboratory examination of the tissue specimen may not be possible. Only clearly benign pigmented lesions can be treated. Check with your doctor for a clearance for the treatment.

6. Allergic reactions: In rare cases, local allergies to tape, preservatives used in cosmetics or topical preparations have been reported. Systemic reactions (which are more serious) may result from prescription medicines. Allergic reactions may require additional treatment.

7.Wear sunscreen of SPF 50 or higher before and after treatment to protect your skin. We highly recommend you use sunscreen at all times.

8. I understand that exposure of my eyes to light could harm my vision. I will keep the eye protection on at all times during the treatment session.

9. Compliance with the after-care guidelines is crucial for healing, prevention of scaring, hyper-pigmentation, and hypopigmentation. 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 any inconveniences occur.

ACKNOWLEDGEMENT

My questions regarding the procedure have been answered satisfactorily. I understand the procedure and understand the risks. I hereby release (individual) and (facility) and (doctor) from all liabilities associated with the above indicated procedure.

Client/Guardian Signature _____

Date _____

Practitioner Signature _____

Date _____

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***All patients must sign a consent form before any treatment.**

RF Consent Form

Name: _____Date: _____

I _____ authorize _____ to perform the Radio Frequency System procedure. I am aware that these treatments will probably result in fat/cellulite reduction. I understand and accept that it may be necessary to undergo more than one treatment in order to achieve the desired goal. I also accept that it may be necessary to use other treatments, including skin care products, nutritional consultation, and program physical activity, in order to achieve the best results. I understand that the skin treated will be red and swollen for a while.

I will keep the treated areas covered with Aloe Vera gel and soothing creams until the skin heals. I understand that this process can take anywhere from 3-6 months and that it might take longer in some cases.

Occasionally, unforeseen mechanical problems may occur, and my appointment will need to be rescheduled. I _____ will make every effort to notify me prior to my arrival to the clinic.

ACKNOWLEDGMENT

My questions regarding the procedure have been answered satisfactorily. I understand the procedure and accept the risks. I hereby release (individual) and (facility) and (doctor) from all liabilities associated with the above indicated procedure.

Client/Guardian Signature _____

Date _____

Practitioner Signature _____

Date _____

***All patients must sign a consent form before any treatment.**

Long Pulse Nd: YAG laser Consent Form

Name: _____Date: _____

I _____ authorize _____ to perform the Long Pulse Nd: YAG laser procedure. I am aware that these treatments will probably result in photo rejuvenation, facial telangiectasias reduction, skin tag removal, hair reduction, leg vein removal and vascular birth mark removal. I understand and accept that it may be necessary to undergo more than one treatment in order to achieve the desired goal. I understand that transient hyper pigmentation can appear, and that minor scaring may appear, though it is understood that this process can take anywhere from 3-6 months and that it might take longer in some cases.

Occasionally, unforeseen mechanical problems may occur, and my appointment will need to be rescheduled. I _____ will make every effort to notify me prior to my arrival to the clinic.

ACKNOWLEDGMENT
My questions regarding the procedure have been answered satisfactorily. I understand the procedure and accept the risks. I hereby release (individual) and (facility) and (doctor) from all liabilities associated with the above indicated procedure.

Client/Guardian Signature _____

Date _____

Practitioner Signature _____

Date _____

***All patients must sign a consent form before any treatment.**

Long Pulse Nd: YAG laser Consent Form

Name: _____Date: _____

I _____ authorize _____ to perform the Long Pulse Nd: YAG laser procedure. I am aware that these treatments will probably result in photo rejuvenation, facial telangiectasias reduction, skin tag removal, hair reduction, leg vein removal and vascular birth mark removal. I understand and accept that it may be necessary to undergo more than one treatment in order to achieve the desired goal. I understand that transient hyper pigmentation can appear, and that minor scaring may appear, though it is understood that this process can take anywhere from 3-6 months and that it might take longer in some cases.

Occasionally, unforeseen mechanical problems may occur, and my appointment will need to be rescheduled. I _____ will make every effort to notify me prior to my arrival to the clinic.

ACKNOWLEDGMENT
My questions regarding the procedure have been answered satisfactorily. I understand the procedure and accept the risks. I hereby release (individual) and (facility) and (doctor) from all liabilities associated with the above indicated procedure.

Client/Guardian Signature _____

Date _____

Practitioner Signature _____

Date _____

***All patients must sign a consent form before any treatment.**

IR Consent Form

Name: _____Date: _____

I _____ authorize _____ to perform the Infrared System procedure. I am aware that these treatments will probably result in skin tightening. I understand and accept that it may be necessary to undergo more than one treatment in order to achieve the desired goal. I also accept that it may be necessary to use other treatments, including skin care products, nutritional consultation, and program physical activity, in order to achieve the best results.

I understand that the skin treated will be red and swollen for a while. I will keep the treated areas covered with Aloe Vera gel and soothing creams until the skin heals. I understand that this process can take anywhere from 3-6 months and that it might take longer in some cases.

Occasionally, unforeseen mechanical problems may occur, and my appointment will need to be rescheduled. I_____ will make every effort to notify me prior to my arrival to the clinic.

ACKNOWLEDGMENT

My questions regarding the procedure have been answered satisfactorily. I understand the procedure and accept the risks. I hereby release (individual) and (facility) and (doctor) from all liabilities associated with the above indicated procedure.

Client/Guardian Signature _____

Date _____

Practitioner Signature _____

Date _____

***All patients must sign a consent form before any treatment.**

Er: YAG laser Consent Form

Name: _____ Date: _____

I _____ authorize _____ to perform the Er: YAG laser System procedure. I am aware that these treatments will probably result in Skin Resurfacing, Skin Rejuvenation of benign skin disorders removal. I understand and accept that it may be necessary to undergo more than one treatment in order to achieve the desired goal. I understand that transient hyper pigmentation can appear and that erythema and edema may appear. I understand that this process can take anywhere from 3-6 months and that it might take longer in some cases.

Occasionally, unforeseen mechanical problems may occur, and my appointment will need to be rescheduled. I _____ will make every effort to notify me prior to my arrival to the clinic.

ACKNOWLEDGMENT
My questions regarding the procedure have been answered satisfactorily. I understand the procedure and accept the risks. I hereby release (individual) and (facility) and (doctor) from all liabilities associated with the above indicated procedure.

Client/Guardian Signature _____

Date _____

Practitioner Signature _____

Date _____

Nd: YAG QS Carbon Treatment Consent Form

Name:

_____Date:_____

I authorize _____ to perform a Nd: YAG QS Laser & Carbon Lotion procedure.

I am aware that these treatments are intended to improve the skin's appearance of the following: skin dullness, fine lines & wrinkles, mild – moderate active acne, and benign pigmented lesions. I understand and accept that it is necessary to conduct more than one treatment in order to achieve results. I also accept that it may be necessary to use other manners of treatments, including skin care products, needed to blend color, reduce sun damage and more. The skin treated may be red and swollen after the treatment and for possibly a few weeks afterwards not limited to. Keep the treated areas covered with Aloe Vera gel and soothing creams. This process will take between 1 – 3 weeks. **We are unable to treat clients who are taking ACCUTANE and PHOTOSENSITIZING medications.**

I _____ understand that I must complete a Medical History Form, which must be updated if any changes occur during the treatment period. I certify the information on my Medical History Form to be true and correct. I also certify that I have not withheld or omitted any medical information.

The following problems may occur with treatment:

1.) **Scarring:** The Nd: YAG QS system can create a bruising and a moderate burn or blister to the skin.
2.) **Hyperpigmentation and hypopigmentation:** have been noted to occur after treatments, especially in people who have a darker complexion. This usually resolves within weeks, but it can take as long as 3-6 months in some cases. Permanent color change is a rare risk. If you have dark skin, a skin lightening cream may be advised to reduce the melanin in your skin before treatment. Avoiding sun exposure before and after the treatment is crucial to reduce the risk of color change and burns.

3.) **Infection:** although infections following the Nd: YAG QS & Carbon Lotion treatment are unusual, bacterial, fungal, and viral infections can occur. Herpes simplex virus infections around the mouth can occur following a treatment. This applies to individuals with a past history of Herpes simplex virus infections in the area. Should any type of skin infection occur, additional treatment including antibiotics will be necessary. **If you have a history of Herpes simplex virus in the treatment area we recommend preventative therapy.**

4. **Bleeding:** pinpoint bleeding is rare but can occur following pigmented lesion treatment procedures. Should bleeding occur, additional treatment may be necessary.
5. **Skin tissue pathology:** Energy directed at the skin lesion may potentially vaporize the lesion. Laboratory examination of the tissue specimen may not be possible. Only clearly benign pigmented lesions can be treated. Check with you doctor for a clearance for the treatment.
6. **Allergic reactions:** In rare cases, local allergies to tape, preservatives in cosmetics or topical preparations have been reported. System reactions (which are more serious) may result from prescription medicines. Allergic reactions may require additional treatment.
7. Wear sunscreen of SPF 50 before, after and between treatments to protect your skin. We highly recommend that you use sunscreen at all times.
8. I understand that exposure of my eyes to the laser radiation could harm my vision. I will keep the eye protection on at all times during the treatment session.
9. Compliance with the aftercare guidelines is crucial for healing, prevention of scarring, hyper-pigmentation, and hypopigmentation. 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 any inconveniences occur.

ACKNOWLEDGEMENT

My questions regarding the procedure have been answered satisfactorily. I understand the procedures and I understand the risks associated. I hereby release _____ (treatment operator) and _____ (facility) from all liabilities associated with the above indicated procedure.

Client/Guardian Signature: _____Date: _____

Practitioner Signature: _____Date: _____

CC PEEL CARBON CORRECTING LASER PEEL

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***All patients must sign a consent form before any treatment.**

Q-Switch Nd: YAG laser Consent Form

Name: _____Date: _____

I _____ authorize _____ to perform the Q-Switch Nd: YAG laser System procedure. I am aware that these treatments will probably result in Tattoo removal. I understand and accept that it may be necessary to undergo more than one treatment in order to achieve the desired goal. I understand that transient hyper pigmentation can appear, and that minor scaring may appear, I understand that I will have to make a small tattoo in my axils before I will start tattoo removing in an exposed area. I will keep the treated areas covered with Aloe Vera gel and soothing creams until the skin heals.

I understand that this process can take anywhere from 3-6 months and that it might take longer in some cases. Occasionally, unforeseen mechanical problems may occur, and my appointment will need to be rescheduled. I _____ will make every effort to notify me prior to my arrival to the clinic.

ACKNOWLEDGMENT
My questions regarding the procedure have been answered satisfactorily. I understand the procedure and accept the risks. I hereby release (individual) and (facility) and (doctor) from all liabilities associated with the above indicated procedure.

Client/Guardian Signature _____

Date _____

Practitioner Signature _____

Date _____