XERF | GENERAL INFORMED CONSENT

I request and authorize _____ or a designated, licensed healthcare professional, using the CYNOSURE LUTRONIC XERF, to perform a procedure on me known as:

The nature and effects of the procedure, the risks, involved, as well as alternative methods of treatment have been fully explained to me by the physician or designated person and I understand them.

I have been thoroughly and completely advised regarding the procedure. I understand that the practice of medicine and surgery is not an exact science and no results have been guaranteed. I certify that no guarantees have been made by anyone regarding the procedure(s) I have requested and authorized. I understand that possible adverse effects may include but are not limited to bleeding, infection, scarring, skin contour irregularities, asymmetry, burns, allergic reaction and topical anesthesia related complications can occur and should be discussed and understood.

I understand the importance of pre-treatment and post-treatment instructions and that my failure to comply with these instructions may increase the possibility of complications.

I agree to have photographs taken of the area to be treated before/after procedure: Yes ☐ No ☐

I certify that I have read the above, that the explanations referred to therein were made to my satisfaction, and that I fully understand such explanations and the above information.

Signed: _____ Date: _____

(Patient or person authorized to consent for the patient)

Ciao Bella ISLAMORADA

XERF | MEDICAL HISTORY FORM

Last Name: _____ First Name: _____ Address: _____

City: _____ State: _____ Zip Code: _____

Telephone: Home: _____ Work: _____ Cell: _____

Date of Birth: _____

Sex: Female ☐ Male ☐

Family Doctor: _____ Pharmacy: _____

Emergency Contact: _____

Phone: _____ Phone: _____ Phone: _____

Which body area/areas or condition would you like treated?

_____

PLEASE ANSWER ALL OF THE FOLLOWING QUESTIONS:	YES	NO
1. Do you have ANY current or chronic medical illnesses? *Disclose any history of heart, urticaria, diabetes, autoimmune disorders or any immunosuppression, blood disorders, cancer, bacterial or viral infections, medical conditions that significantly compromise the healing response, skin photosensitivity disorders, or other condition(s) or illness.* Please List:	☐	☐
2. Do you have ANY current or chronic skin conditions? *Also disclose any history of vitiligo, eczema, melasma, psoriasis, allergic dermatitis, any diseases affecting collagen including Ehlers-Danlos syndrome, scleroderma, skin cancer, or other skin condition(s).* Please List:	☐	☐
3. Are you currently under a doctor's care? If so, for what reason? _____	☐	☐
4. Do you take/use ANY medications (prescription and nonprescription), vitamins, herbal or natural supplements, on a regular or daily basis? Please List:	☐	☐
5. Have you ever had Gold Therapy Treatment (chrysotherapy, aurotherapy, Gold sodium thiomalate (GST))?	☐	☐

	YES	NO
6. Are there any topical products (both medical and non-medical) that you use on your skin on a regular or daily basis? Please List:	☐	☐
7. Do you take/use ANY systemic/oral steroids (e.g., prednisone, dexamethasone)?	☐	☐
8. Do you have ANY allergies to medications, foods, latex or other substances? Please List:	☐	☐
9. (For women) are you or could you be pregnant?	☐	☐
10. (For women) are menstrual periods regular, or have you ever been diagnosed with Polycystic Ovarian Disorder?	☐	☐
11. Do you have a history of herpes I or II in the area to be treated?	☐	☐
12. Do you have a history of keloid scarring or hypertrophic scar formation?	☐	☐
13. Do you have a history of light induced seizures?	☐	☐
14. Do you have any open sores or lesions?	☐	☐
15. Do you have any history of radiation therapy in the area to be treated?	☐	☐
16. In the last six (6) months, have you used any of the following: anticoagulants or blood-thinning medications; photosensitizing medications; or anti-inflammatory or blood thinning medications? *Please List product name and date last used:*	☐	☐
17. In the last three (3) months, have you used any of the following products: glycolic acid or other alphahydroxy or betahydroxy acid products, exfoliating or resurfacing products or treatments? *Please List product name and date last used:*	☐	☐
18. Do you have or have you ever had any permanent make-up, tattoos, implants, or fillers, including, but not limited to, collagen, autologous fat, Restylane®, etc.? *If yes, please list locations on or in the body and dates:* _____	☐	☐
19. Do you have or have you ever had any Botulinum, such as Botox® or Dysport®? *If yes, please list locations on or in the body and dates:* _____	☐	☐
20. Have you taken Accutane® (or products containing isotretinoin) in the last 12 months?	☐	☐
21. Have you taken Tretinoin (like Retin-A®, Renova®) in the last 6 months?	☐	☐
22. Have you had any unprotected sun exposure, used tanning creams (including sunless tanning lotions) or tanning beds or lamps in the last 4-6 weeks?	☐	☐

Signature: _____ Date: _____