Tampa Laser Hair Removal
GO SHAVELESS

Natural or artificial sun exposure in the past 3-4 weeks pre-op or the following 3-4 weeks post-op plan	NO	YES:	
Use of self-tanners or tan enhancer caps within the past 3-4 weeks pre- op plan	NO	YES:	
Photosensitive herbal preparations (St. John's Wort, Ginkgo Biloba, etc.) or aromatherapy (essential oils)	NO	YES:	
Diseases which may be stimulated by light at 515 nm to 1200 nm, such as history of Systemic Lupus Erythematosus or Porphyria	NO	YES:	
Pregnant or possibility of pregnancy, postpartum, or nursing	NO	YES:	
Inflammatory skin conditions (dermatitis, active acne, etc.)	NO	YES:	
Presence or history of active cold sores or herpes simplex virus	NO	YES:	
HIV	NO	YES:	
Active cancer (currently on chemotherapy or radiation)	NO	YES:	
Previous skin cancer?	NO	YES:	
Medical history of keloids	NO	YES:	
Intake of isotretinoin within the past year	NO	YES:	
Medical history of Koebnerizing isomorphic diseases (vitiligo, psoriasis)	NO	YES:	
Any known allergy?	NO	YES:	
Any tattoo and/or pigmented lesion on requested treatment area that should be protected?	NO	YES:	
List of additional current medication taken			
Hormonal or endocrine disorders (PCOS or uncontrolled diabetes?)	NO	YES:	
Previous hair removal procedures on requested treatment area (other IPL/laser, wax, electrolysis, etc.)	NO	YES: what/when?	
Any observed modification (color, size, texture, and border) on the lesion to be treated?	NO	YES:	
Any hair on requested treatment area that should not be removed?	NO	YES:	
Age of lesion onset?	NO	YES:	
Previous skin procedures on requested treatment area (Botox, fillers, peels, etc.)	NO	YES: what/when?	
Intake of aspirin or anti-coagulants?	NO	YES:	
Easy bruising?	NO	YES:	
Swollen legs or pain after long standing/sitting?	NO	YES:	
Previous vein surgery on requested treatment area (sclerotherapy, stripping, etc.)	NO	YES: what/when?	
My signature certifies that I have duly read and understood the content of this informed consent, and gave the accurate information as to my health condition. I hereby freely consent to laser hair removal and/or laser skin treatments.		Please Initial _____	
_____ Name of Patient (please print)		_____ Signature of Patient	_____ Date