Naficy Medical Group
27512 Calle Arroyo, Suite A, San Juan Capistrano, CA 92675 ~ (949) 489-0773

CONSULTATION FORM

Name ____ Age _____ Sex ____ Date______________

Area(s) to be treated today: ____

Past or present Illnesses/Medical Conditions, please list:

Allergies: ____

____

____

Present Medications (Accutane, Antibiotics, Aspirin, Antiviral, Iron supplements, Gold therapy, Coumadin, drugs which may cause photosensitivity this includes herbal supplements):

List medications and dosages: ____

____

____

Please list dosage of oral antibiotics/Accutane and date of last dose taken:

____

Please list any topical medications you are using: ____

____

____

Do you have a history of any autoimmune disease?____

Do you have a history of HSV I or HSV 2 ____

Do you have any implants/injectables/permanent make-up? If so, please list:

____

____

Do you have any tattoos? Is so, please list location: _____________________________________

Are you pregnant? Yes_______ No_________ N/A ________ LMP

History of keloids/hypertrophic scars: yes ____ no_____

Tanning history (including direct sun, self tanners, spray tans) Please list and include last date of use:

____

____

CONSULTATION FORM (continued)

Previous Laser Treatment: (specify date/number of treatments/frequency/tissue response/devise used, if known):

____

____

____

Previous Hair Removal History, if applicable: Wax epilation _____ Mechanical epilation (plucking) ______
Electrolysis_______ Bleaching ______ Shaving ______

Frequency/and last use of above modalities: ____

Other type treatment:

Have you ever had a cosmetic peel/cosmetic procedure? Please list ___________________________________

____

FOR STAFF ONLY:

Recommendations: Discussion with provider

1. Treatment options (testing, brown or black hair responds best, number of treatments).
2. Client expectations: (understand need for multiple treatments, after care, possible side effects, etc).
3. Physician consultation (If required in your state) before or after test for a treatment recommendation.
4. Full treatment schedule process (waiting period in-between treatments, expected results.,
5. Possible side effects (hyperpigmentation, hypopigmentation, purpura, scarring, textural changes, burns, blistering, pain or discomfort and erythema) and length of time to expect healing if side effects occur.
6. Specifics of area to be treated. Test small area for tissue response BEFORE full treatment.
7. Importance of sun exposure avoidance and the use of a broad spectrum zinc oxide or titanium dioxide UVA/B sun block with SPF 30 or higher. during the entire treatment program.
8. Sensation of the laser/DCD spray and the option for topical anesthesia or other cooling methods.
9. Benefits of laser treatment (possible long-term hair removal),
10. Cost of treatment (payment schedule, cost of multiple treatments versus single payment per visit).
11. Eyewear protection and laser safety measures required for patient and provider. Patients may sense light while wearing proper eye protection.
12. Importance of post care instructions/procedures.

Photo taken today: YES ____ NO ___
COMMENTS: ____

____

I agree that the information listed above has been reviewed and presented with my clear understanding of what this procedure involves. All of my questions have been addressed to my satisfaction.

Signed:____Date _______________

Witness:____Date _______________