WHELIHAN LASER
6801 Lake Worth Rd., Suite 100W
Greenacres, FL 33467
(561) 795-4507

Patient Medical History – Laser Hair Removal Treatment

Date _____ Who may we thank for referring you? _____

Name _____ Date of Birth: _____

Address _____ City/St _____ Zip _____

Phone: Home or Work _____ Cell _____ Cell carrier _____

Email Address: _____

Age _____ Sex _____ Marital Status (circle): Single / Married / Divorced / Widowed

Race: Caucasian ____ African American ____ Hispanic ____ Asian ____ Other _____

Is your family aware of this treatment? _____ Social Security # _____
How much time do you spend in the sun? _____
Do you go to a tanning booth? _____ How often? _____
Do you wear sunscreen? _____ How often? _____ SPF? _____
What products are you currently using on your face/body?_____

Have you ever had any laser treatment? _____ Specify: _____

Have you ever been treated by an Endocrinologist? _____ Specify: _____
Date of last physical exam: _____
Are you currently being treated by a physician for any reason? _____ Specify: _____

_____

How would you describe your skin based on the following scale:

_____ Type I	Light white skin. Always burns, never tans
_____ Type II	Light white skin. Always burns, sometimes tans
_____ Type III	Medium white skin. Sometimes burns, always tans
_____ Type IV	Dark/Olive White or Asian skin. Rarely burns, always tans
_____ Type V	Light brown skin
_____ Type VI	Medium to dark brown, African & African American skin

List any medications you are currently taking (including over the counter medications, vitamins and herbal supplements: _____

List any medications you are allergic to: _____

Do you have a history of taking any of the following medications?

Birth Control	____	Testosterone	____	Antidepressants	____	Thyroid	____
Chemotherapy	____	Minoxidil	____	Tetracycline	____	NSAIDS	____
Anabolic steroids	____	Aldactone	____	Blood Thinners	____	DHEA	____

Have you ever used or have had any of the following? (please circle)

Accutane Retin-A Chemical Peel Glycolic Acid Peel Pulsed Dye Laser
Laser Resurfacing Sunburn Skin Grafts Liposuction

GENERAL MEDICAL HISTORY - Do you have or have you ever had diseases or conditions of:

Acne	____	Hemophilia	____
Cancer	____	Hepatitis	____
Cold Sores	____	H.I.V.	____
Fever Blisters	____	Keloid Scars	____
Dermatitis/Eczema	____	Moles	____
Diabetes	____	Bleeding Disorders	____
Genital Herpes	____	Problems with Healing	____
Tattoo	____	Allergies:	
Shingles	____	Drug	____
Heart Condition	____	Environmental	____
Herpes Type I/II	____	Latex	____
Asthma	____	Breathing Problems	____
Chest Pains	____	Circulatory Problems	____
Tuberculosis	____	Chemo / Radiation	____
Epilepsy	____	High Blood Pressure	____
Skin Allergies	____	Psoriasis	____
Vitiligo	____	Metal Plates	____
Seizures	____	Blood Diseases	____
Blood Transfusions	____	Malignancies	____

Comments on any of the above: _____

_____

Please circle the areas you are interested in having treated (today and in the future):

Upper Lip Chin Neck Face Underarms Bikini
Back Shoulders Back of Neck Chest Abdomen Breast
Legs Feet/Toes Arms Buttocks Hands/Fingers Other _____

Do you have any pitting, scarring, moles or tattoos in the areas to be treated? _____

What type of hair removal have you used and/or are currently using? _____

When was the last time you used this method? _____

FEMALES ONLY:

Are you pregnant? _____ When was your last menstrual cycle? _____
Do you have menstrual irregularities? _____
Have you experienced fertility problems? _____
Are you taking hormone supplements? _____

I understand that health information is important for safe and effective laser treatment. I acknowledge that all information given is truthful, complete and accurate to the best of my knowledge and I agree to update you, throughout the treatment process, of any changes in my health assessment, changes in medications and physical conditions.

_____ _____
Patient Signature Date

_____ _____
Parent/Guardian of minor Signature Date

WHELIHAN LASER
6801 LAKE WORTH RD., SUITE 100 W
GREENACRES, FL 33467
(561) 795-4507

Consent Form: Laser Hair Removal Treatment
Alexandrite (755-nm) & ND YAG (1064-nm)

Name _____ Date: _____

I. The purpose of this treatment is to reduce or eliminate unwanted hair. I understand that the results from this treatment vary with each individual. Multiple treatments may be necessary.

II. The Apogee Elite laser produces an intense burst of light that is absorbed by the hair follicle selectively. All personnel in the treatment room, including myself, will wear protective eyewear to prevent eye damage from the intense laser light.

III. The sensation of the light is uncomfortable and may feel like a slight pin prick or sensation of heat, which may last for a few hours. The use of anesthesia is at the discretion of the case provider. However, all of the options and possible side effects will be discussed with me.

IV. The area should be treated delicately following treatment. The treated area may be red for a period from a few hours to a few days. I have been informed that blistering, scarring, hypopigmentation (lightening of the skin) and hyperpigmentation (darkening of the skin) are possible risks and complications of the procedure. I understand that sun or tanning bed exposure and not adhering to post-care instructions may increase my chance of complications.

V. I consent to the taking of photographs during the course of my laser therapy for the purpose of medical education. These photographs may be used for teaching or publication, as the case provider deems appropriate. If I do not want my photographs to be published, I will express it in writing.

VI. Not providing my medical history before proceeding with a light-based treatment could impact treatment results and cause complications. I agree to update and inform the provider of any changes in medical history information prior to each treatment.

I have read and received a copy of the Post Treatment Skin Care Instructions. I have read and understand all information presented to me before signing this consent form. I have also been given the opportunity to ask questions. Before and after-treatment instructions have been discussed with me. The procedure, potential benefits and risks, and alternative treatment options have been explained to my satisfaction. I freely consent to the proposed treatment today as well as for future treatments as needed.

_____ _____
Patient (or Legal Guardian) Signature Date

_____ _____
Witness Signature Date

WHELIHAN LASER
6801 Lake Worth Rd., Suite 100W
Greenacres, FL 33467
(561) 795-4507

Patients of Dr. Whelihan, M.D.

"Under Florida law, Physicians are generally required to carry medical malpractice insurance or otherwise demonstrate financial responsibility to cover potential claims for medical malpractice. DR. WHELIHAN HAS DECIDED NOT TO CARRY MEDICAL MALPRACTICE INSURANCE. This is permitted under Florida law subject to certain conditions. Florida law imposes penalties against non-insured Physicians who fail to satisfy adverse judgments arising from claims of medical malpractice. This notice is provided pursuant to Florida law".

_____
Patient (or legal guardian) Signature

_____
Date

WHELIHAN LASER
6801 Lake Worth Rd., Suite 100W
Greenacres, FL 33467
(561) 795-4507

Laser Hair Removal
Post Treatment Skin Care Instructions
(Keep this page)

- The area being treated cannot be exposed to the sun or tanning beds. A broad spectrum (UVA, UVB) sunscreen of SPF 30 or higher should be applied whenever exposed to the sun.
- Immediately following treatment, the area may show some redness and/or some swelling. Blistering may occur.
- During the healing phase the area must be treated delicately. Do not rub, scratch, squeeze or pick. If a crust develops, keep it moist with aloe gel and let it fall off on its own.
- Apply a thin layer of aloe vera gel to the treated area several times a day to keep area moist for 2-3 days.
- Do not scrub the area. Pat the area dry. Do not shave over the area if swelling, crusting or scabbing is present.
- If swelling occurs, apply ice. Wrap the ice in a soft cloth. Discomfort or stinging may be relieved with Tylenol.
- If you use makeup, it must be applied and removed delicately. Apply only fresh makeup (purchased in the last 90 days). Avoid using makeup for at least 24 hours.
- Do not use abrasive face washes on the treated area. Do not exfoliate any treated areas for 2-3 weeks after treatment.
- Avoid sports and/or strenuous exercises for 2-3 days following treatment. The sweat may cause skin irritation. Also avoid hot tubs for 24 hours after treatment.
- In case of signs of infection (pus, tenderness, fever) contact the office immediately.
- The treated hairs will exfoliate or push out in approximately 1-2 weeks.

Post treatment skin care instructions must be followed to prevent any complications. Please contact the office at 561-795-4507 with any questions or concerns regarding your treatment.