

## Facial Vessels & Leg Vein Therapy History Card

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_  
Street Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Telephone (Home) \_\_\_\_\_ (Work) \_\_\_\_\_ (Cell) \_\_\_\_\_  
Email Address \_\_\_\_\_  
How Referred \_\_\_\_\_

Previous Treatments Yes  No  Date Last Treated \_\_\_\_\_ Area \_\_\_\_\_  
Skin Type  I  II  III  IV  V  VI (See Skin Type Evaluation Sheet)  
Vein Color \_\_\_\_\_  
Presence of Tattoos  Yes  No *(There is a possibility of inadvertant tattoo removal during leg vein treatment)*  
If yes, location: \_\_\_\_\_  
Tanning History (Indoor/Outdoor): \_\_\_\_\_  
Exercise Regimen - Frequency: \_\_\_\_\_

### MEDICAL HISTORY

Are you under a doctor's care? If so, for what are you being treated? \_\_\_\_\_  
Recent surgery or injury \_\_\_\_\_  
Are you currently on any mood altering or depression medication?  Yes  No  
Allergies: *(ex. Latex, Foods, Medications, Lidocaine)* \_\_\_\_\_  
Present Medications: *(ex. Accutane, Aspirin, Antiviral, Iron Supplements, Coumadin, St. John's Wort or any causing Photosensitivity)*  
\_\_\_\_\_  
Present Herbal and Vitamin Supplements: \_\_\_\_\_  
Keloids/Hypertrophic Scars:  Yes  No  
Women, when was your last menstrual period? \_\_\_\_\_

### ***Consultation Check List***

- Discuss 2 types of lasers used for leg vein therapy
- Treatment options *(testing, leg vein and size, vein color that responds best, number of treatments)*
- Client expectations *(need for multiple treatments, aftercare, possible side effects, etc.)*
- Physician consultation before and/or after test for treatment recommendation
- Full treatment schedule process in detail *(waiting period, in-between treatments, immediately after and after several weeks)*
- Possible Side effects *(hyperpigmentation, hypopigmentation, purpura, bruising, scarring)* and healing time of side effects.
- Specifics of area being treated *(Test small area for tissue response BEFORE full treatment)*
- How long before starting exercise regimine
- Importance of avoiding sun exposure and using sunscreen during the entire treatment program.
- Sensation of the laser/DCD spray and the option for topical anesthesia if requested
- Cost of treatment and payment schedule *(cost of package versus payment per treatment)*

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.**

Print Name: \_\_\_\_\_ Technician: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

### Fitzpatrick Skin Typing

- Skin Type I      Never Tans, always burns (extremely fair skin, blonde/ red hair)
- Skin Type II     Occasionally tans, usually burns (fair skin, sandy to brown hair, green/brown eyes)
- Skin Type III    Often tans, sometimes burns during first exposure to sun (medium skin, brown hair)
- Skin Type IV     Always tans, never burns (olive skin, brown hair)
- Skin Type V      Never burns (dark brown skin, black hair)
- Skin Type VI     Never Burns (Black skin, black hair)

We do **NOT** recommend laser therapy if any of the below conditions exist. Please check any box that describes your current health condition. Please advise the technician of any medications you are taking (see form)

- Photosensitivity Disorder
- Herpes (active)
- Shingles (active)
- Seizure disorder triggered by light

SCORE	0	1	2	3	4	Scores
What is your eye color	Light Blue	Blue, Grey or Green	Blue/Hazel	Brown	Brownish Black	
What is the natural color of your hair	Sandy/Red	Blonde	Dark Blonde/Light Brown	Chestnut/Brown	Black	
What is the color of your non-exposed skin	Reddish	Very Pale	Pale with beige tint	Light Brown	Dark Brown	
Do you have freckles on unexposed areas	Many	Several	Few	Incidental	None	
What happens the first time you stay in the sun too long	Painful, Redness, Blistering, Peeling	Blistering followed by peeling	Burns sometimes followed by peeling	Rarely burns	Never burns	
To what degree do you turn brown	Hardly or not at all	Light color tan	Reasonable tan	Tan very easily	Turn dark brown quickly	
Do you turn brown after the first several hours of sun exposure	Never	Seldom	Sometimes	Often	Always	
How does your face react to the sun	Very Sensitive	Sensitive	Normal	Very resistant	Never had a problem	

						TOTAL	SKIN TYPE		
When did you last expose your body to sun or tanning booth or tan creme	More than 3 months ago	2 - 3 months ago	1 - 2 months ago	Less than one month ago	Less than 2 weeks ago				
When did you last expose the area to be treated to sun	More than 3 months ago	2 - 3 months ago	1 - 2 months ago	Less than one month ago	Less than 2 weeks ago				

Skin Type Score	Fitzpatrick Skin Type
0 - 7	I
8 - 16	II
17 - 25	III
25 - 30	IV
Over 30	V - VI

SCORE WITH TANNING HABITS			
TOTAL	SKIN TYPE		

\_\_\_\_\_  
Client Signature

\_\_\_\_\_  
Date

**SKIN ANALYSIS FOR FACIAL VESSELS AND LEG VEIN THERAPY**

Have you used Retin A in the last 2 weeks in the area to be treated? [ Y / N ]

Are you currently taking Accutane for acne, or have you taken it in the last six months? [ Y / N ]

If yes, explain: \_\_\_\_\_

Have you had a chemical or acid peel on your face in the last 3 months? \_\_\_\_\_

If yes, where and when and what percent? \_\_\_\_\_

Have you seen a dermatologist in the last 6 months? [ Y / N ]

If yes, are you using dermatologist strength skincare products? [ Y / N ]

List products: \_\_\_\_\_

Please list all skincare products you are currently using on your face, neck, and chest \_\_\_\_\_

\_\_\_\_\_

Are you currently using a topical antibiotic on your face for acne? [ Y / N ]

Have you taken oral antibiotics in the last two weeks? [ Y / N ]

Do you have an tattoos, permanent makeup or body piercings in the area to be treated? [ Y / N ]

Where? \_\_\_\_\_

Have you had any injectibles in the treatment area in the last month? [ Y / N ]

(ie. Juvederm, Botox, Restylane) \_\_\_\_\_

\_\_\_\_\_  
Client Signature

\_\_\_\_\_  
Date

## CONSENT FORM FOR FACIAL VESSEL AND LEG VEIN THERAPY

I \_\_\_\_\_ authorize Anti-Aging Centers of Connecticut, LLC and its designated staff to perform Leg Vein Therapy on me. I have been advised of pre and post treatment procedures and the possible adverse reactions which are as follows:

PRETREATMENT — N.d YAG 1064nm is a device that produces an intense but gentle burst of light that fragments and remove the vessels under 1.5mm in diameter with selective destruction with minimum harm to the surrounding tissue. To protect my eyes from the intense light, I will have my eyes covered with an opaque material or wear laser protective glasses. I will feel a cool spray then a hot pulse from the laser.

I have been informed that scarring, blistering, purpura, hypopigmentation (lightening of the skin) or hyperpigmentation (darkening of the skin) are possible risks and complications of this procedure. Usually, if these occur, they are temporary and can resolve in a few weeks or months depending on the skin type and ethnic background. For the best results, I have been informed that multiple treatments may be necessary.

Anesthesia is usually not necessary as this laser also uses a cooling device that delivers a spray to the surface of the skin to reduce discomfort, when the laser pulse is delivered. If additional anesthesia is needed, all options will be discussed with me.

POST TREATMENT REACTION AND CARE. I understand that immediately following the laser treatment; the treated area will appear as a red discoloration (erythema) and have slight edema (swelling), which may last up to 2-3 days or longer. I may experience transient purpura, bruising, and may note nodule like lumps in the vessel. The bruising may last up to 3 weeks or longer, depending on the size and color of the vessel. Possible hyperpigmentation (increased brown color) or hypopigmentation (lighter color pigment) may occur within two weeks of treatment. If hyperpigmentation occurs, a bleaching cream may be prescribed to reduce the pigmentation. Contact Anti-Aging Centers of Connecticut, LLC at 203-848-1484 or after hours 203-887-1237.

Antibiotic ointment or some other soothing ointment or gel, or Aloe Vera gel may be used for a few days after the treatment. Improper care of the treated area may increase the chance of scarring or skin textural changes. This has been discussed with me.

- I must avoid sun exposure on area while doing treatments and the reasons have been discussed with me.
- Use of a 25+ sun block post treatment is recommended.
- Avoid Scrubbing or trauma to the treated area.
- Topical creams and medications may be resumed when erythema and skin irritation decrease.

I consent to the taking of photographs during the course of my therapy for the purpose of medical education. I understand that my identity will not be revealed on the photographs or corresponding text.

By signing below, I acknowledge that I have read and understand all information presented to me before signing this consent. I hereby release the Anti-Aging Centers of Connecticut, LLC, its medical staff and technicians from any liability associated with the above.

\_\_\_\_\_  
Signature (Client)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature (Technician)

\_\_\_\_\_  
Date



## CANCELLATION

This is a reminder to all our clients about our cancellation policy, which can be also be found posted in our offices. This policy states that there must be a 24 hour notice of cancellation for you scheduled appointment or your account will be charged a \$25.00 cancellation fee.

We will give a courtesy reminder call before your appointment but it is the responsibility of the client to cancel within 24 hours.

Thank you for your attention with this matter

As a client of Anti Aging Centers of Connecticut, LLC, I understand that if I do not call to cancel my appointment within 24 hours of the appointment, I will be charged \$25.00.

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Signature

Date