FORM
A CLINIC FOR FUNCTIONAL & REGENERATIVE MEDICINE

LASER TREATMENT CONSENT & SKIN TYPING

Please complete both pages before your consultation

PATIENT INFORMATION

Name _____ **DOB / Age** _____ **Sex** _____ **Date** _____

Area(s) to be treated _____

MEDICAL HISTORY

Past or present illnesses / medical conditions _____

_____

Allergies _____

Current medications, supplements & dosages — include Accutane, antibiotics, aspirin, antivirals, iron, gold therapy, Coumadin or other blood thinners, and any drug or herbal supplement that causes photosensitivity

_____

_____

Oral antibiotics / Accutane — dose & date of last dose _____

Topical medications (retinoids, acids, other irritants) _____

CONTRAINDICATION SCREENING

Check Yes or No for each item and explain any "Yes."

Do you have, or have you had...	Yes	No	Details
Pacemaker or internal defibrillator			
Metal or other implants, injectables or permanent makeup in the treatment area			
Tattoos (list location)			
Skin cancer, pre-malignant moles, or any history of cancer			
Severe heart condition or other serious illness			
Pregnant or nursing (LMP: _____)			
Autoimmune disease, HIV/AIDS, or immunosuppressive medication			
Light-sensitive condition (lupus, porphyria, epilepsy)			
Cold sores / HSV-1 or HSV-2, especially in the treatment area			
Diabetes, PCOS or other poorly controlled hormone disorder			
Active sores, psoriasis, eczema or rash in the treatment area			
Keloids, hypertrophic scars, poor wound healing, or very dry, fragile skin			
Bleeding disorder, or blood thinners other than low-dose aspirin			
Accutane in the last 6 months; tetracyclines or St. John's Wort in the last 2 weeks			
Surgery in the treatment area in the last 3 months, or not fully healed			
Deep chemical peel or laser resurfacing of the face in the last 3 months			
Botox or fillers in the last 4 weeks			

TREATMENT HISTORY

Tanning (sun, tanning bed, self-tanner, spray tan) — type & last date _____

Previous laser / IPL — dates, # of treatments, device, skin response _____

_____

Other cosmetic procedures or peels _____

Hair removal ☐ Waxing ☐ Plucking ☐ Electrolysis ☐ Bleaching ☐ Shaving **Frequency / last used** _____

FoRM
A CLINIC FOR FUNCTIONAL & REGENERATIVE MEDICINE

LASER TREATMENT CONSENT & SKIN TYPING

Patient name: _____

FITZPATRICK SKIN TYPING

Circle one answer per row and write its score (0–4) in the last column. Recent tanning — sun, tanning bed or tanning cream — can change your result.

Question	0	1	2	3	4	Score
Genetic disposition						
Natural eye color	Light blue, green or gray	Blue, gray or green	Blue	Dark brown	Brownish black	
Natural hair color	Sandy, red	Blonde	Chestnut / dark blonde	Dark brown	Black	
Skin color (unexposed areas)	Reddish	Very pale	Pale, beige tint	Light brown	Dark brown	
Freckles on unexposed areas	Many	Several	Few	Incidental	None	
Reaction to sun exposure						
Too long in the sun	Painful redness, blistering, peeling	Blistering, then peeling	Burn sometimes, then peeling	Rarely burn	Never burn	
How much do you tan?	Hardly or not at all	Light tan	Reasonable tan	Tan very easily	Turn dark brown quickly	
Brown within hours of sun?	Never	Seldom	Sometimes	Often	Always	
Face reaction to sun	Very sensitive	Sensitive	Normal	Very resistant	Never a problem	
Tanning habits						
Last sun / tanning bed / cream exposure	Over 3 months ago	2–3 months ago	1–2 months ago	Under 1 month ago	Under 2 weeks ago	
Treatment area exposed to sun?	Never	Hardly ever	Sometimes	Often	Always	
					TOTAL SKIN TYPE SCORE	

Score key: 0–7 = Type I · 8–16 = Type II · 17–25 = Type III · 26–30 = Type IV · Over 30 = Type V–VI **Fitzpatrick Type** _____

BEFORE YOUR TREATMENT

- No Botox for **2–3 weeks** before treatment. No fillers (hyaluronic acid, collagen) for **3–4 weeks** before treatment.
- No intentional tanning for **2 weeks** before, especially before IPL. Use SPF 30+ zinc oxide or titanium dioxide sunscreen outdoors throughout your treatment program.
- Stop irritating topical products **2–3 days** before. No waxing, tweezing or needle epilation for **6 weeks** before hair removal.
- Arrive to your appointment with cleansed skin. ***If you are receiving Laser Hair Removal, please shave the treated area within 24 hours prior to your appointment.***
- Use topical anesthetic only as directed by your physician.
- Dental crowns, braces or metal implants can make nearby areas more sensitive; your clinician may shield them with gauze or dental rolls.

POSSIBLE SIDE EFFECTS

Side effects are uncommon and usually temporary. They may appear during or shortly after treatment; darker skin types may react 1–2 days later. Possible effects include discomfort, redness and swelling, crusting, blistering or burns, purpura (bruising), lightening or darkening of the skin, textural change, and scarring. **Report any reaction to your physician right away.**

CONSENT

I confirm the information on this form is complete and accurate, and I will tell my provider about any changes before each session. I have read the instructions, side effects and contraindications above. The procedure, expected results, need for multiple treatments, aftercare and costs have been explained to me, and all of my questions have been answered to my satisfaction. I consent to laser treatment at FoRM Health.

Patient signature _____ Date _____ Witness signature _____ Date _____

FOR STAFF ONLY — PROVIDER DISCUSSED WITH PATIENT

- ☐ Treatment options & number of sessions
- ☐ Expectations, aftercare, side effects & healing time
- ☐ Physician consultation & recommendation
- ☐ Test spot before full treatment
- ☐ Sun avoidance & SPF 30+ physical sunscreen
- ☐ Sensation, cooling & topical anesthesia
- ☐ Cost & payment schedule
- ☐ Eye protection & laser safety

Photo taken ☐ Yes ☐ No **Fitzpatrick type confirmed** _____ **Provider initials** _____

Comments _____