INTENSE PULSED LIGHT (IPL™)

CONSENT AND MEDICAL HISTORY QUESTIONNAIRE

Please read and initial each statement. Complete, underline or circle individual selection accordingly.

PATIENT NAME: ____ **DATE OF BIRTH:** _____ / _____ / ________

Initials

- I authorize Doctor __________________ to perform IPL™ treatments on me in an effort to improve Dry Eye Disease due to Meibomian Gland Dysfunction / Dyschromia / Hyperpigmentation / Hair Reduction / PWS / Hemangioma / Angioma / Rosacea / Telangiectasia / Other:______________________________ ________
- I understand that without eye protection, IPL applied near the eyes may cause severe ocular complications. ________
- I understand that there is a rare possibility of side effects or serious complications including permanent discoloration and scarring. I am aware that careful adherence to all advised instructions will help reduce this possibility. ________
- I understand the below list of short-term effects and agree to follow matching guidelines: ________
  - Flaking of pigmented lesions – crusts may take 5 to 10 days to disappear and it is important not to manipulate or pick which may otherwise lead to scarring.
  - Discomfort – during the procedure, I might experience a sensation similar to a rubber band snap which degree will vary per my skin condition and area sensitivity but that does not last long. A mild "sunburn" sensation may follow for typically up to one hour and will be reduced with application of cooling and soothing creams.
  - Reddening and swelling – severity and duration depend on the intensity of the treatment and the sensitivity of the area to be treated. These phenomena may be reduced with application of cooling and/or anti-inflammatory creams.
  - Bruising my rarely occur and may last up to 2 weeks.
- I understand that sun exposure or tanning of any sort is not aligned with the pre and/or post-care instructions and may increase the chance for complications. ________
- The procedure as well as potential benefits and risks have been thoroughly explained to me and I have had all my related questions answered. ________
- Pre- and post-care instructions have been discussed and are completely clear to me. ________
- I understand that results may vary with each individual and acknowledge that it is impossible to predict how I will respond to the treatment and how many sessions will be required. ________
- I consent to photographs being taken for the purpose of documenting my progress and response to the treatment and be kept solely in my medical record. ________
- I consent to photographs being used for medical education or publication with applied discretion and not revealing my identity. ________
- I agree to review the following IPL™ pre-treatment compliance checklist along with my Physician and bring accurate and updated data, to the best of my knowledge. ________

For Dry Eye Disease due to Meibomian Gland Dysfunction:

Ocular surgery or eyelid surgery within 6 months prior to the first IPL™ session?		
Neuro-paralysis in the planned treatment area, within 6 months prior to the first IPL™ session?	NO	YES
Uncontrolled eye disorders affecting the ocular surface, for example active allergies?	NO	YES
Pre-cancerous lesions, skin cancer or pigmented lesions in the planned treatment area?	NO	YES
Uncontrolled infections or uncontrolled immunosuppressive diseases?	NO	YES
Ocular infections within 6 months prior to the first IPL™ session?	NO	YES
Prior history of cold sores or rashes in the perioral area or in the planned treatment area that could be stimulated by light at a wavelength of 560 nm to 1200 nm, including: Herpes simplex 1 & 2, Systemic Lupus erythematosus, and porphyria?	NO	YES
Within 3 months prior to the first IPL™ session, use of photosensitive medication and /or herbs that may cause sensitivity to 560-1200 nm light exposure, including: Isotretinoin, Tetracycline, Doxycycline, and St. John's Wort?	NO	YES
Radiation therapy to the head or neck within 12 months prior to the first IPL™ session?	NO	YES
Planned radiation therapy within 8 weeks after the last IPL™ session?	NO	YES
Treatment with chemotherapeutic agent within 8 weeks prior to the first IPL™ session?	NO	YES
History of migraines, seizures, or epilepsy?	NO	YES
Tattoos in the planned treatment area?	NO	YES
Exposure to sun or artificial tanning during 3-4 weeks prior to treatment?	NO	YES
Any remaining suntan, sunburn, or artificial tanning products?	NO	YES

Natural or artificial sun exposure in the past 3-4 weeks pre-op or the following 3-4 weeks post-op has been reviewed with me.	NO	YES
Use of self-tanners or tan enhancer caps within the past 3-4 weeks pre-op.	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 400 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, 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 or 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 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?		
Previous skin procedures on requested treatment are (Botox, fillers, peels, etc…)	NO	YES:_ what/when? ____________________
Intake of aspirin or anti-coagulants?	NO	YES:______________
Easy bruising?	NO	YES

Patient Name____ Date of Birth ____/____/_______
(Print Name)

My signature certifies that I duly read and understood the content of this informed consent form, that I gave the accurate information as to my health condition, and that nothing has changed since I completed the consent form. I hereby freely consent to OptiLight IPL ™ treatments.

Signature ____ Date ____/____/_______

Signature ____ Date ____/____/_______

Signature ____ Date ____/____/_______

Signature ____ Date ____/____/_______

Signature ____ Date ____/____/_______

Signature ____ Date ____/____/_______

Signature ____ Date ____/____/_______

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