

SOUTHERN LASER SALON, INC.
PATIENT CONSULTATION FORM
FOR TREATMENT OF LEG/FACE VEINS

Date: _____

Name: _____ Age: _____ DOB: _____

Chief Complaint: _____

Past Medical History: _____

Surgical History: _____

Medications: _____

Allergies: _____

History:	Yes	No	Date of last exposure
Sclerotherapy	X	X	_____
Acutance	X	X	_____
Cold sores/herpes	X	X	_____
Previous laser tx	X	X	_____
Keloids	X	X	_____

Circle One:

- Benefits of procedure discussed: **Yes No**
- Contraindications reviewed: **Yes No**
- Risks reviewed (pigment changes, bruising, swelling, infection, scarring, reappearance of vessels, blistering): **Yes No**
- Probability of success reviewed: **Yes No**
- Patient educated about anticipated consequences if treatment (tx) is not performed; and alternative procedures available: **Yes No**
- Verbal and written post-treatment instructions given to patient: **Yes No**
- Famvir Rx given: **Yes No**
- Bleaching agent Rx given: **Yes No**
- Next appointment scheduled: **Yes No** Date: ____/____/____

Comments:

Signature of consultant: _____

Date: ____/____/____