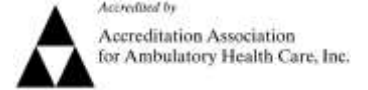




CARY SKIN CENTER
Aesthetic Surgery & Laser Center
Evaluation Form



Date: _____

Name: _____ Last First Middle (Spouse) SS# : _____ - _____ - _____

I. CHIEF COMPLAINT:

II. HISTORY:

What areas are you interested in having treatment ?

Location(s): _____

What are you interested in being done? _____

Has the area(s) been treated before ? Yes O No O

Date: _____ Doctor: _____ Location: _____ Method: _____
Date: _____ Doctor: _____ Location: _____ Method: _____
Date: _____ Doctor: _____ Location: _____ Method: _____

Please describe how you tolerated the above procedure(s) ? _____

Did you experience ? [] Changes in skin pigmentation [] Difficulty with healing [] Other problems (explain below)

Additional Comments: _____

III. PAST MEDICAL HISTORY:

Do you have a history of any of the following? (If yes explain):

Table with 8 columns: Yes, No, [Condition], Yes, No, [Condition], Yes, No, [Condition]. Rows include Artificial Joints, Liver Disease/ Hepatitis, Bleeding Problems, etc.



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CURRENT MEDICAL PROBLEMS:

- 1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

PRIOR HOSPITALIZATIONS/SURGERY (Provide Dates)

- 1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

CURRENT MEDICATIONS

(include aspirin, vitamins, laxatives, and over the counter products)

- 1. _____ 7. _____
2. _____ 8. _____
3. _____ 9. _____
4. _____ 10. _____
5. _____ 11. _____
6. _____ 12. _____

DRUG ALLERGIES

Table with 2 columns: Medication, Reaction. Rows 1-6.

List any other medications, pills, or other preparations you take intermittently: _____

IV. SOCIAL HISTORY:

Occupation: _____ Employer _____
Do You Smoke? Yes O No O Amount: _____
Do you drink alcohol? Yes O No O Amount: _____

V. FAMILY HISTORY:

Skin Cancer: Yes O No O _____
Abnormal scarring: Yes O No O _____
Other: _____

VI. PHYSICAL EXAMINATION:

Temp: _____ BP: _____ HR: _____ Weight: _____ (Kg) Height _____

General Physical Examination:

Glogau Photoaging:

Table with 5 columns: 4 Type, Classification, Photoaging, Patient Age, Makeup Use. Rows for Type I-IV.

Fitzpatrick Skin Type:

- I
□ II
□ III
□ IV
□ V
□ VI

Other Comments/Findings: None



VII. ASSESSMENT:

VIII. Counsel:

- The patient was thoroughly educated on their above diagnosis. A detailed description of the procedure and its follow up requirements were outlined. Clinical pictures of patients were reviewed with the patient. A handout was given to the patient, which outlines the entire procedure, the postoperative course, and the risks, benefits, advantages, disadvantages, and potential complications. The handout was reviewed with the patient, and the patient acknowledged full understanding of this outline.
- The risks, benefits, advantages, disadvantages, and potential complications of potential treatments were outlined with the patient in detail. Detailed information and consent forms were provided for each procedure they were interested in.
- The alternatives to the procedure were reviewed with the patient in detail. These include no therapy, other laser therapies, dermabrasion and excision for tattoos, and topical medications for some diagnoses. The comparative risks, benefits, and possible complications of these procedures compared to VersaPulse C therapy were discussed in detail as well.
- Patient was counseled to avoid sun exposure, and use a daily sunscreen and protective clothing while undergoing cosmetic therapy.
- We recommended that any individual considering cosmetic surgery should carefully weigh the benefits and risks. **No guarantees of improvement in a patient's condition can be made.**

IX. PLAN:

- Consent form handed out.
- Quotation provided for desired services. See quotation form.
- All of the patient's questions and concerns were addressed.
- Financial Policy handed out.
- Pre-operative photographs were obtained.

Additional Comments:

Physician Signature: _____
Viehman Flynn Clark

Date: _____

Time: _____ am/pm

Patient Name: _____
Last, First