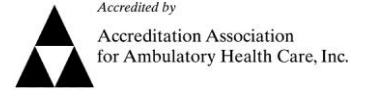




CARY SKIN CENTER
Aesthetic Surgery & Laser Center
Evaluation Form



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 No

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:

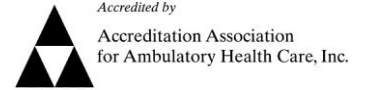
III. PAST MEDICAL HISTORY:

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

Yes	No		Yes	No		Yes	No	
<input type="radio"/>	<input type="radio"/>	Artificial Joints	<input type="radio"/>	<input type="radio"/>	Family History of Bleeding Problems	<input type="radio"/>	<input type="radio"/>	Heart Disease
<input type="radio"/>	<input type="radio"/>	Liver Disease/ Hepatitis	<input type="radio"/>	<input type="radio"/>	Heart Murmur	<input type="radio"/>	<input type="radio"/>	Rheumatic Fever
<input type="radio"/>	<input type="radio"/>	Bleeding Problems	<input type="radio"/>	<input type="radio"/>	Artificial Heart Valve	<input type="radio"/>	<input type="radio"/>	Keloids
<input type="radio"/>	<input type="radio"/>	Difficulty Healing Wounds	<input type="radio"/>	<input type="radio"/>	Pacemaker: _____	<input type="radio"/>	<input type="radio"/>	Kidney Disease
<input type="radio"/>	<input type="radio"/>	Emotional Disorders	<input type="radio"/>	<input type="radio"/>	High Blood Pressure	<input type="radio"/>	<input type="radio"/>	Blood Clots
<input type="radio"/>	<input type="radio"/>	Fever Blisters	<input type="radio"/>	<input type="radio"/>	Diabetes	<input type="radio"/>	<input type="radio"/>	Glaucoma
<input type="radio"/>	<input type="radio"/>	Thyroid problems	<input type="radio"/>	<input type="radio"/>	Hernias	<input type="radio"/>	<input type="radio"/>	Taken medicine Accutane
<input type="radio"/>	<input type="radio"/>	Fainting or becoming lightheaded during blood draws or medical procedures						
<input type="radio"/>	<input type="radio"/>	Any complications with previous surgeries						
<input type="radio"/>	<input type="radio"/>	Prior Cosmetic Procedures: _____						



CARY SKIN CENTER
Aesthetic Surgery & Laser Center



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

Medication Reaction

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

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

IV. SOCIAL HISTORY:

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

V. FAMILY HISTORY:

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

VI. PHYSICAL EXAMINATION:

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

General Physical Examination:

Glogau Photoaging:

4 Type:	Classification	Photoaging	Patient Age	Makeup Use
	Type I - "no wrinkles"	EARLY: mild pigment changes, no keratoses, minimal wrinkles	20-30's	Minimal or no
	Type II - "wrinkles in motion"	EARLY TO MODERATE: early solar lentigines, palpable ak's, wrinkles with facial motion	30-40's	Usually wears; some foundation
	Type III - "wrinkles at rest"	ADVANCED: prominent dyschromia, telangiectasia, visible ak's, wrinkles at rest	50's or older	Always wears heavy makeup and foundation
	Type IV - "only wrinkles"	SEVERE: yellow gray skin color, prior skin ca, wrinkled throughout	60 or above	Can't wear: "cakes & cracks"

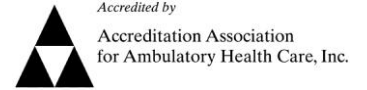
Fitzpatrick Skin Type:

- I
- II
- III
- IV
- V
- VI

Other Comments/Findings: None




CARY SKIN CENTER
Aesthetic Surgery & Laser Center



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: _____
Clark Flynn

Date: _____

Time: _____ am/pm

Patient Name: Last, First