SelectSkinMD

Electrolysis
Patient Pretreatment Questionnaire

Name_____

Do you have a history of unusual scarring? _____yes _____no

Do you have a history of Herpes simplex (fever blister, cold sores) recurring in the area to be treated?

_____yes _____no

Are you under the care of a physician? _____yes _____no If so, why?_____

Are you pregnant? _____yes _____no

Please check any that apply: _____Diabetic _____Hepatitis _____Pacemaker

_____Allergies

Please check any you are allergic to: _____Local Anesthesia _____Rubbing Alcohol

_____Witch Hazel

Hair Removal methods used previously: _____

_____

Have you ever had electrolysis treatment before? _____yes _____no If so, when?_____

PLEASE READ:

I am aware that Electrolysis does involve a series of treatments which can be completed in approximately one to three years depending on what is causing the hair growth and what means of temporary hair removal has been used. Persons that have been tweezing an area for years will require more treatments in that area because the hairs will be course and distorted. Hairs that have not been tweezed will require fewer treatments due to their soft texture and shallow roots. It is important to stay on a regular schedule due to the cycle in which hair grows (between 2-4 weeks). After a series of consistent treatments between 4-6 months, the regrowth will become less and less and more time will be scheduled between office visits.

INFORMED CONSENT FOR ELECTROLYSIS HAIR REMOVAL TREATMENT

Electrolysis is a medically approved method of permanent hair removal. Only actively growing hairs and follicles are affected and several treatments are necessary.

The treatments, expectations from treatment, and post treatment care have been explained to me and my questions regarding the treatment have been answered to my satisfaction. _____ (Initials)

I understand that the treatment works on actively growing hairs and follicles and not on any that are dormant. For this reason, it requires several sessions to complete a course of treatment.
_____ (Initials)

I am aware of the following possible risks associated with this treatment including, but not limited to:
Infection-Skin infections can occur any time the skin is broken

Discomfort- Some discomfort may be experienced during this treatment. Topical anesthesia may be used if necessary.

Pigment changes (skin Color) - During the healing process, the treated areas may become darker or lighter than surrounding skin. This is usually temporary but, on rare occasions, may be permanent.

I certify that I have read this entire consent form and that all of my questions have been answered, and I understand and agree to the information provided above. I consent to and authorize Katy Jankauskas to perform Electrolysis.

_____ _____
Patient signature Date

_____
Witness