LIGHTWAVE™ Patient Medical History & Consent Form

Section A: Patient Contact Information

(To be filled out by the patient. Please use ink and print.)

First Name: _____ Middle Initial:____ Last Name: _____

Date of Birth:____/ ____ /_____ (mm/dd/yyyy) Gender: ☐ Male ☐ Female

Street Address: _____

City: _____ State: _____ Zip: _____

Home Phone: (_____) _____-_____ Alt. Phone: (_____) _____-_____

E-Mail Adress:_____

Family Doctor: _____ Phone number: _____

May we contact you in the future for specials and promotions? ☐ Yes ☐ No

Section B: Patient History

Before undergoing LIGHTWAVE™ therapy, you must complete this section.

Light therapy is not for everyone. Specific medications or conditions can cause a person to develop sensitivity to light. The following questions are intended to help determine if light therapy is the best choice of treatment for you.

Please read the following questions and circle YES OR NO.

Have you ever had any of the following conditions:

Acute or Cutaneous Porphyria	YES	NO
Photophobia	YES	NO
Epilepsy and Seizures	YES	NO
Hypomelanism (albinism)	YES	NO
If you answered yes to any of the above conditions then you are probably not a candidate for light therapy treatments due to the immense amount of pulsing and continuous light being administered.		

Skin Cancer	YES	NO
Eye disease/retinal abnormalities	YES	NO
Migraines	YES	NO
Diabetes	YES	NO
If you answered yes to any of the above conditions then it is highly recommended you consult with your physician before commencing with light therapy.		

Are you currently pregnant or planning to become pregnant in the next eight weeks? YES / NO
If you answered yes then you are not a candidate for light therapy.

Do you have any contagious or infectious conditions? YES / NO

Are you currently taking or have you taken any antibiotics in the past 7 days? YES / NO

Do you take aspirin products, anti-inflammatory medicines or headache medicines? YES / NO

If yes, which one(s)? _____
Patients who frequently use anti-inflammatory and aspirin products often require more treatments to achieve desired results.

Please list all previous surgeries and dates: _____

_____

Are there any other conditions we should be made aware of? If yes, please explain: _____

_____

Please check off any cosmetic treatments you have had in the past 2 weeks:

_____ Facial Peels
_____ Injectables
_____ Microcurrent facial
_____ Microdermabrasion
_____ Oxygen facials
_____ Laser Resurfacing
_____ IPL (Intense Pulse Light)
_____ Pulse Dye
_____ ALA (aminolevulinic acid)
_____ Laser Hair Removal
_____ Tattoo Removal
Other: _____

Please list any cosmetic treatments you have had in the past five years: _____

_____

_____

Were you satisfied with your results? Why or why not? _____

_____

What areas or problems concern you the most? _____

_____

Please carefully look over the following list of medications and check off any you have taken in the past 7 days. These medications have been known to cause light sensitivity and it is recommended that you suspend the medications for 5-7 days before undergoing light therapy. Please be sure to check with your doctor before discontinuing any prescribed medications.

Anti-Arrhythmic

_____ **Amiodarone** (Pacerone® Cordarone® Aratac®)

_____ **Chlorpromazine** (Thorazine®, Chloramead®, Chlordryprom®, Chlor® Promanyl®, Largactil®, Promapar®, Promosol®, Terpium®, Sonazine®)

Acne:

_____ **Oral Isotretinoin** (Accutane®, Accure®, Aknenormin®, Amnesteem®, Ciscutan®, Claravis®, Isohexal®, Isotroin®, Oratane®, Sotret®, Roaccutane®)

_____ **Topical Isotretinoin** (Isotrex®, Isotrexin®)

Anti-Psychotic:

_____ **Haloperidol** (Haldol®)

_____ **Trifluoperazine** (Stelazine®, Clnazine®, Novoflurazine®, Pentazine®, Solazine®, Terfluzine®, Triflurin®, Tripazine®)

Anti-Fungal:

_____ **Griseofulvin** (Grifulvin®)

Antibiotics:

_____ **Tetracycline** (Helidac®, Terra-Cortril®, Terramycin®, Sumycin®, Actisite®, Bristacycline®, Actisite®, Tetrex®, Doxycycline®, Ciprofloxacin®)

_____ **Norfloxacin** (Noroxin®, Quinabic®, Janacin®)

_____ **Ofloxacin** (floxin®, Oxaldin®, Tarivid®)

_____ **Nalidixic acid** (NegGam®, Wintomylon®)

_____ **Ciprofloxacin** (Cipro®, Ciproxin®, Ciprobay®)

_____ **Minocycline** (Minomycin®, Minocin®, Arestin®, Akamin®, Aknemin®, Solodyn®, Dynacin®, Sebomin®)

_____ **Oxytetracycline**

_____ **Demeclocycline**

_____ **Lymecycline**

Cancer:

_____ **Methotrexate** (MTX®, Aminopterin®, Ledertrexate®)

Arthritis:

_____ **Auranofin** (Ridaura®)-***If a patient is taking this medication, they are not a candidate for light therapy.***

The above drugs are currently the most common medications associated with photosensitivity and are by no means a complete list of all photosensitive medications. Herbs and over the counter medications such as psoralen and St. John's Wort can also cause sensitivity to light so it is important to disclose any and all medications or herbs you are currently taking.

Please list any additional medications NOT listed above you may currently be taking or have taken in the past 7 days:

_____

Section C: Pre-Treatment Skin Assessment

The following questions are designed to help us assess the current condition of your skin and identify your skin type.

Do you currently smoke? _____ How much and how often? _____

Have you ever smoked? _____ How long did you smoke for? _____

Do you drink alcohol? _____ How much and how often? _____

Do you take vitamins regularly? _____ Do you exercise regularly? _____

Do you practice healthy eating habits on a regular basis? _____

Do you currently utilize tanning beds or sun bathe on a regular basis? _____

Do you wear sunscreen regularly? _____

If yes, please specify which sunscreen for which area and the SPF factor:

Eyes _____

Face and Neck _____

Body _____

Do you currently use professional skincare products? _____

If yes, please specify which products for which area:

Eyes _____

Face and Neck _____

Other: _____

Circle the choice that best describes your skin.

TYPE I- Highly sensitive, always burns, never tans.
Example: Red hair with freckles

TYPE II- Very sun sensitive skin, burns easily, tans with difficulty.
Example: Fair skinned, fair haired Caucasians

TYPE III- Sun sensitive skin, sometimes burns, slowly tans to light brown.
Example: Darker Caucasians.

TYPE IV- Minimal sun sensitivity, occasionally burns, always tans to moderate brown.
Example: Mediterranean.

TYPE V- No sun sensitivity, rarely burns, tans well.
Example: Asian, Hispanic and Arabic

TYPE VI- No sun sensitivity, never burns and tans with ease, deeply pigmented.
Example: Darker Blacks.

Section D: Consent for LIGHTWAVE™ Therapy

I _____, consent to and authorize _____ to perform LIGHTWAVE™ treatments on me. The purposes of these treatments are for _____ _____.

LIGHTWAVE™ Therapy is a non-ablative procedure which utilizes Light Emitting Diode (LED) technology to treat a variety of skin imperfections such as fine lines and wrinkles, scarring, blemishes, uneven skin tone and texture, and stretch marks. The LIGHTWAVE™ treatment is a gentle and natural treatment much like the process of photosynthesis, also known as photo-bio-stimulation ("...the stimulation of life processes with light…"). The LIGHTWAVE™ system may use visible red (red light), blue (blue light) and infrared (invisible light) energy to stimulate your body's own regenerative metabolism at the cellular level. By stimulating the body's tissues to convert light energy into cellular energy (ATP), a LIGHTWAVE™ treatment provides energy that your cells can use to:

- accelerate the production of collagen and elastin
- increase cellular permeability, allowing for increased cellular nutrient intake
- increase the removal of excess fluid and waste products from the cells
- increase the production of macrophage (scavenger) cells for the removal of toxins and scar tissue
- increase lymphatic drainage
- increase vascularization (blood flow) to the surface of the skin

Risks and Side Effects:
LIGHTWAVE™ treatments are non-invasive and are intended not to produce any thermal damage or pain. Even though appropriate measures are taken to reduce side effects, they cannot be completely eliminated in every case. It is important to notify the treatment facility if you have any problems or concerns such as uncomfortable heat from the pad or panel, prolonged redness of the skin, swelling, itching or severe headaches during or after the treatment. These are all indications of sensitivity to light in which case you would want to discontinue the treatment immediately. These side effects rarely occur and usually subside within 24 hours of discontinuing the treatment. It is also import to notify the treatment facility if any conditions to your medical history change such as becoming pregnant or diagnosis of a medical condition. To prevent any eye sensitivity or damage, protective eyewear is to be worn during all treatment sessions. I understand the treatment may involve risks of complication or injury from both known and unknown causes, and I freely assume these risks. Alternative treatment choices are available. With this in mind, I am choosing this non-invasive treatment option.

Pre/Post Treatment Instructions:
It is important that the treated area be cleaned to remove all moisturizers and creams prior to starting any treatment session. In order to maximize your treatment, you must drink at least 8 oz. of water before and after all treatment sessions, practice healthy eating habits, limit sun bathing, alcohol consumption, and smoking while undergoing your series of light therapy sessions and up to six weeks following your treatment. Most clients will continue to see a marked improvement in their skin over the 12 week treatment period even after the initial LED sessions have concluded. As with any cosmetic treatment, individual clinical results will vary from person to person and no guarantees can be made that expected or anticipated

results will be achieved. I am aware that follow-up treatments may be necessary for desired results. Most patients require a number of treatment sessions over several weeks with gradual results occurring over time. I agree to adhere to any and all safety precautions and regulations during the treatment. No refunds will be given for treatments received. I have read and understand the Pre and Post Treatment Instructions. I agree to follow these instructions carefully. I understand that compliance with recommended pre and post procedure guidelines are critical in determining the effectiveness of the treatment sessions.

Photographs:
Due to the nature of the treatment, it is important to obtain before, during and after photographs to clearly document the results that are being achieved throughout the treatment period. I consent to the taking of clinical photography and its use for controlled purposes both in publication and presentations. I fully understand my identity will be protected.

The nature and purpose of the treatment has been explained to me. I have carefully read and understand this agreement and fully understand its contents. All of my questions have been answered to my satisfaction and I consent to the terms of this agreement. Alternative methods of treatment have been explained to me and I understand that I have the right to refuse treatment. I am aware that this is a release of Liability, a waiver of legal rights and contracts between LTW International L.L.C, _____ and the undersigned.

I release LTW International L.L.C, _____, medical staff and technicians from liability associated with this procedure. I certify that I am a competent adult of at least 18 years of age and sign this at my own free will. This consent and waiver form is voluntarily executed and shall be binding upon my spouse, relatives, legal representatives, heirs, administrators, successor, and assigns.

Client signature: _____ **Date:** _____

Please print name: _____

Witness: _____ **Date:** _____