

**BBL PATIENT HISTORY/CONSENT**

**-Area(s) to be treated:** \_\_\_\_\_

**-Are you tan or have you had recent sun exposure in the above areas: Y / N OR used self-tanners in the last 2 weeks: Y / N**

**-Do you use sunscreen: Y / N SPF: \_\_\_\_\_ How often: \_\_\_\_\_x/day**

**-Do you have a history of HSV (cold sores) in the area to be treated: Y / N Are you taking preventative medication: Y / N**

**-Do you have any medication and/or skin related allergies: Y / N If yes, please list:**

\_\_\_\_\_

**-Please list all medications you are currently taking, or have taken in the last 2 weeks (oral, topical, OTC, and herbal):**

\_\_\_\_\_

\_\_\_\_\_

**-Please indicate if you have used any of these topical medications/products in the last week (in the area to be treated):**

Fillers/Botox: Y / N Retin- A: Y / N Glycolic Acid: Y / N Salicylic Acid: Y / N Bleaching Cream: Y / N

**-Do you have cosmetic tattoos/permanent makeup in the area to be treated: Y / N If yes, where: \_\_\_\_\_**

**-Have you had Accutane, chemotherapy, or radiation in the last 6-12 months: Y / N If yes, please list: \_\_\_\_\_**

**-Have you been diagnosed with any disorder associated with photosensitivity, bleeding, or the inability to heal: Y / N**

Please explain: \_\_\_\_\_

**-(For female patients) Are you pregnant: Y / N Breastfeeding: Y / N**

I consent to the taking of photographs for the purpose of monitoring the progress of my treatments; these photographs will remain in my chart and not be used for any other reason.

I am aware that BBL is an elective procedure and there are possible risks associated with these treatments, similar to any other medical procedure. Although very rare, risks may include scarring and permanent skin discoloration, as well as more common short-term effects such as redness, swelling, burning, bruising, blistering, and temporary skin discoloration. I understand that carefully following the pre/post treatment instructions is crucial for treatment safety, proper healing, and in the prevention of an adverse event/complication. These side effects have all been fully explained to me and I accept the risks of the BBL treatment series.

I certify that I have been given the opportunity to ask questions and that I have read and fully understand the content of these consent forms.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

Witness: \_\_\_\_\_ Date: \_\_\_\_\_