MonaLisa Touch™

4716 Alliance Blvd. Pavilion II, Suite 270
Plano, Texas 75093
214-577-1777

MonaLisa Touch™ – Patient Questionnaire & Health History

Name: _____ Date: _____
(Last) (First) (Middle)

Date of Birth: _____ Age: _____ Occupation: _____

Home Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Work: _____

E-Mail Address: _____ May we contact you via E-Mail? ( ) YES ( ) NO

In Case of Emergency Contact: _____ Relationship: _____

Home Phone: _____ Cell Phone: _____ Work: _____

Primary Care Physician's Name: _____ Phone: _____

Address: _____
Address City State Zip

Pharmacy Name: _____ Phone: _____

Address/Cross Streets: _____

Marital Status (check one): ( ) Married ( ) Divorced ( ) Widow ( ) Living with Partner ( ) Single

In the event we cannot contact you by the mean's you've provided above, we would like to know if we have permission to speak to your spouse or significant other about your treatment. By giving the information below you are giving us permission to speak with your spouse or significant other about your treatment.

Spouse's Name: _____ Relationship: _____

Home Phone: _____ Cell Phone: _____ Work: _____

Pharmacy Name: _____ Phone: _____

Social:

( ) I am sexually active
( ) I want to be sexually active
( ) My sex has suffered
( ) I haven't been able to have an orgasm

Habits:

( ) I smoke _____cigarettes/cigars per day
( ) I drink _____alcoholic beverages per day
( ) I drink more than 10 alcoholic beverages per week
( ) I use caffeine _____ times a day

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SURGERY/ HISTORY: Hysterectomy: ( ) YES ( ) NO Ovaries: ( ) IN ( ) OUT

Last Pap: _____(mo/yr) Normal: ( ) YES ( ) NO Last Mammogram: _____(mo/yr) Normal: ( )YES ( ) NO

SYMPTOMS: _____

Medications currently taking: _____

Any known drug allergies: _____

Have you ever had any issues with anesthesia? ( ) Yes ( ) No
If yes please explain: _____

Current Hormone Replacement Therapy: _____

Past Hormone Replacement Therapy: _____

Nutritional/Vitamin Supplements: _____

Surgeries, list all and when: _____

_____

Other pertinent Information: _____

_____

Preventative Medical Care:
( ) Medical/GYN Exam in the last year.
( ) Mammogram in the last 12 months.
( ) Bone Density in the last 12 months.
( ) Pelvic ultrasound in the last 12 months.

High Risk Past Medical/Surgical History:
( ) Breast Cancer.
( ) Uterine Cancer.
( ) Ovarian Cancer.
( ) Hysterectomy with removal of ovaries.
( ) Hysterectomy only.
( ) Oophorectomy Removal of Ovaries.

Birth Control Method:
( ) Menopause.
( ) Hysterectomy.
( ) Tubal Ligation.
( ) Birth Control Pills.

Medical Illnesses:
( ) High blood pressure.
( ) Heart bypass.
( ) High cholesterol.
( ) Hypertension.
( ) Heart Disease.
( ) Stroke and/or heart attack.
( ) Blood clot and/or a pulmonary emboli.
( ) Arrhythmia.
( ) Any form of Hepatitis or HIV.
( ) Lupus or other auto immune disease.
( ) Fibromyalgia.
( ) Trouble passing urine or take Flomax or Avodart.
( ) Chronic liver disease (hepatitis, fatty liver, cirrhosis).
( ) Diabetes.
( ) Thyroid disease.
( ) Arthritis.
( ) Depression/anxiety.
( ) Psychiatric Disorder.

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Date: _____

Patient's name: _____

Patient's DOB: _____

☐ Pre-Treatment 1

☐ Pre-Treatment 2

☐ Pre-Treatment 3

☐ Follow up in _____ months

Please indicate the level of discomfort you are experiencing for each category below					
0	**2**	**4**	**6**	**8**	**10**
Very happy, no hurt 	Hurts just a little bit 	Hurts a little more 	Hurts even more 	Hurts a whole lot 	Hurts as much as you can imagine 
Pain (0-10) _____			**Vaginal burning** (0-10) _____		
Vaginal itching (0-10) _____			**Vaginal dryness** (0-10) _____		
Painful sexual intercourse (Dyspareunia) (0-10) _____			**Painful urination (Dysuria)** (0-10) _____		

Comments:_____

_____

_____

_____

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MonaLisa Touch™ – Informed Consent to Treat

I request and authorize _____ to perform a procedure on me using the MonaLisa Touch laser.

Therapy using the Mona Lisa Touch laser is an appropriate treatment for vaginal symptoms due to menopause.

The laser produces small columns of damage in the soft tissue of the vaginal walls. These columns help stimulate new collagen production which helps promote mucosal revitalization and improved vaginal vascular health.

The nature and effects of the procedure, the results, as well as alternative methods of treatment have been fully explained to me by the physician or designated person and I understand them.

I have been thoroughly and completely advised regarding the end point of the procedure. I understand that the practice of medicine and surgery is not an exact science and no results have been guaranteed. I acknowledge that the operative result may not meet my expectations. I certify that no guarantees have been made by anyone regarding the procedure(s) that I have requested and authorized.

All persons in the treatment room, including myself, will wear protective eyewear to prevent eye damage.

I understand the procedure is comfortably tolerated without sedation or anesthesia, although a topical numbing cream may be offered to me to aid in the comfort of the probe insertion. The treatment takes about 5 (five) minutes to complete. There are no known associated side effects following this procedure. I should refrain from strenuous exercise and sexual activity for 2 (two) days after the procedure.

I have read and understand all information presented to me before signing this consent. I have also been given the opportunity to ask questions and understand the information provided.

Patient Signature: _____ Date: _____

Signature: _____ Date: _____
(Person authorized to consent for the patient)

Witness: _____ Date: _____

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MonaLisa Touch™ Pre and Post Treatment Instructions

It is important to follow your treatment provider's instructions before and after treatment

Pre-Treatment Recommendations: Patient

- Shower or bathe the morning of treatment, so that the area to be treated is clean
- Understand and sign a Consent to Treat form & Patient Questionnaire before treatment

Post-Treatment Instructions

- Schedule follow up visits as recommended by your treatment provider
- Refrain from vaginal sexual activity for 48 hours after treatment
- Most patients resume normal activity as tolerated immediately after procedure

Other instructions:

_____

_____

_____

_____

If you have any questions about these instructions or the procedure,
please contact your physician.

Patient Signature: _____ Date: _____

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Cancellation & No Show Policy

When you call to schedule an appointment, the time is blocked off especially for you. During your appointment, we make every effort to run on time and will not allow another person to take your appointment time.

Since these appointments are set aside for you and you only, we require a 24 hour notice of cancellation so we can offer the appointment slot to someone else.

Failure to provide the required notice will result in a non-cancellation/late cancellation/no show fee that must be settled before another appointment can be scheduled

Fees:

A 15 - 30 minute missed appointment will be charged $25
A 45 minute missed appointment will be charged $50
A 1 hour missed appointment will be charged $100
Any appointment over an hour will be charged an additional $50 per hour

We believe this policy allows us to provide the best possible care and customer service for all of our patients. Thank you for your understanding and compliance with this policy.

Patient has read and understands the Policy stated above.

All questions have been answered to my satisfaction.

_____ Date: _____
Signature of Patient

_____ Date: _____
Signature of Patients Parent/Legal Guardian, if Patient is Under 18

_____ Date: _____
Medical Aesthetics of North Dallas Rep

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HIPAA

In our efforts to comply with the health information privacy act, HIPAA, we need to be certain that we guard your privacy according to your wishes when it comes to your family, friends and co-workers.

Please circle your choice responses to the following questions:

May we leave messages concerning your appointments/treatments with a co-worker, receptionist or secretary that regularly answers your calls?	YES	NO
May we leave messages on a voicemail at work?	YES	NO
May we leave messages on an answering machine at home?	YES	NO
May we leave messages on your cell phone?	YES	NO
May we leave messages with a spouse or significant other?	YES	NO
Is there anyone that is not listed above that we can give information to? If so, please specify.	YES	NO

_____

For any children above the age of 18, still living at home, may we discuss your appointments/treatments with your parent(s) or Guardian?	YES	NO
I would like to receive regular email updates and/or newsletters:	YES	NO

_____
Email address

You must inform us, in writing, of any changes in your directives.
This record will be kept in your file with you acknowledgement of receipt of our Notice of Privacy Practices.

_____ Date: _____
Signature of Patient

_____ Date: _____
Signature of Patients Parent/Legal Guardian, if Patient is Under 18

_____ Date: _____
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Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED & DISCLOSED AND HOW YOU CAN RECEIVE ACCESS TO THIS INFORMATION.

PLEASE REVIEW CAREFULLY

Medical Aesthetics of North Dallas and its employees collect data through a variety of means including but not necessarily limited to intake forms, phone calls, emails, voice mails, and from the submission of our website's contact page.

Information about your financial situation, medical conditions and spa treatments/services that you provide to us in writing, via email, on the phone (including information left on voice mails), contained in or attached to intake forms, or directly or indirectly given to us, is held in strictest confidence. We do not give out any information about our patients who receive our treatments and/or services, which is considered patient confidential, is restricted by law, or has been specifically restricted by a patient in a signed HIPAA consent form.

Information is only used as is reasonably necessary to provide you with treatments and/or services which may require communication between Medical Aesthetics of North Dallas and health care providers, pharmacies, insurance companies, and other providers.

We are legally obligated to maintain the privacy of your financial situation, medical conditions and spa treatments/services, to provide you with this Notice of Privacy Practices, and to abide by its terms. We reserve the right to change our privacy practices and apply revised privacy practices to your protected information.

I acknowledge that I have read and understand the information provided to me in the above Notice of Privacy Practices. I feel I have been adequately informed and all of my questions have been addressed and answered to my satisfaction.

_____ Date: _____
Signature of Patient

_____ Date: _____
Signature of Patients Parent/Legal Guardian, if Patient is Under 18

_____ Date: _____
Medical Aesthetics of North Dallas Rep