MonaLisa Touch HEALTH HISTORY

Last Name: _____First Name: _____MI:_____
Street Address: _____
City, State, Zip: _____
Phone Number: _____ Email: _____
Date of Birth:_____ Marital Status: __Married __Divorced __Single __Widowed
Emergency Contact: _____ Phone Number: _____
Pharmacy: _____ Phone Number: _____ Cross Streets: _____

GENERAL HEALTH:

Are you allergic to any medications? Yes/No If yes, please list: _____
Medications currently taking: _____
_____
Vitamins & OTC supplements currently taking: _____
_____
Are you currently on a Hormone Replacement Therapy? Yes/No If Yes, please list: _____
Have you ever had any issues with anesthesia? Yes/No If yes, please explain: _____
When was your last menstrual period? (Estimate year if unknown): _____
List all surgeries, and when: _____
_____
Other pertinent information you'd like us to know: _____

Do you smoke or use tobacco? Yes/No **Do you drink alcohol?** Yes/No **Do you use caffeine?** Yes/No

Select all that apply: __I am sexually active __I want to be sexually active __I haven't been able to orgasm
__My sex has suffered __I have completed my family

In the last 12 months, have you had a: (check all that apply)

__Bone density test __Gynecological exam (w/Pap Smear) __Mammogram __Pelvic Ultrasound

High risk past surgical history:

__Breast cancer __Ovarian Cancer __Uterine Cancer __Complete Hysterectomy
__Partial Hysterectomy __Oophorectomy (removal of ovaries only)

Birth control method:

__Birth control pills __Hysterectomy __IUD __Menopause __Tubal Ligation __Vasectomy

Medical illnesses:

__Arrhythmia	__Depression/anxiety	__High blood pressure
__Arthritis	__Diabetes	__High cholesterol
__Asthma/COPD	__Eating disorder	__Insomnia
__Blood clotting defects	__Epilepsy	__Kidney disease
__Cancer	__Fibromyalgia	__Lupus (or other auto immune disease)
__Cardiovascular disease	__Fractures	__Osteoporosis
__Childhood disease	__Gallbladder trouble	__PCOS
__Chronic fatigue	__Heart attack and/or stroke	__Trouble passing urine/bowel
__Chronic liver disease	__Heart bypass	__Thyroid disease
__Colitis/Crohn's disease	__Heart disease	__Varicose veins

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: _____
_____
_____
_____
_____

Informed Consent to Treat

I, _____, authorize MonaLisa Partners and its providers, to perform a procedure on me using the MonaLisa Touch laser.

Therapy using the MonaLisa Touch laser is an appropriate treatment for vaginal/vulvar symptoms due to menopause.

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

The nature and effects of the procedure, the results, as well as the 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 treatment. The known associated side effects following this procedure may include: vaginal spotting, pink, brown, or watery vaginal discharge, irritation, burning upon urination, discomfort, redness, swelling, inflammation, and itching.

I should refrain from strenuous exercise and sexual activity for 2 days after internal treatment and 7 days after external treatment.

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.

_____ Date:_____

Print Patient Name

_____

Patient Signature

_____ Date:_____

Treating Provider

Privacy Practices and Office Policies

Notice of Privacy Practices:

Information about your medical conditions, treatments/services, and financial situation that you provide to us over the phone (including information left on voicemails), in writing, via email, 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 services, which is considered patient confidential, is restricted by law, or has been specifically restricted by a patient in a signed HIPPA consent.

Information is only used as reasonably necessary to provide you with 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 medical conditions, treatments/services, and financial situation, provided by 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.

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 answer the following questions:

May we leave a message on a voicemail? __Yes __No
May we leave a message with your spouse or significant other? __Yes __No

Late 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 who may be in need to be seen. Failure to provide the require notice will result in a **Late Cancellation/No Show Fee of $50** which must be settled before another appointment can be scheduled.

I acknowledge that all the answers to this questionnaire are in fact true and correct. I acknowledge that I have read and understand the information provided to me in the above Notice of Privacy Practices and in the Late Cancellation/No Show Policy.

_____ Date: _____
Printed Patient Name

_____
Patient Signature

_____ Date: _____
MonaLisa Partners Provider/Staff

Pre and Post Care Instructions

Internal PRE Treatment

- Shower or bathe the morning of treatment so the area to be treated is clean.
- Area must be clean and dry without any traces of creams, lotions, lubricants or other substances in that may interact with the laser.
- Clip or trim long pubic hair in the treatment area. It is not necessary to shave or trim your entire pubic region if this is not your typical practice.
- Remove any intra-vaginal appliance, i.e. estrogen ring, diaphragm, menstrual cup, or piercings to arriving to the office for treatment.
- It is recommended you wear cotton underwear and loose fitting pants to your appointment. You may want to bring a panty liner of your choice, or we can provide one to you.

Internal POST Treatment

- Schedule your next appointment 6 weeks out from your first and second treatment.
- Refrain from intimacy for at least 48 hours after treatment.

External PRE Treatment

- Shower or bathe the morning of treatment so the area to be treated is clean.
- Area must be clean and dry without any traces of creams, lotions, lubricants or other substances in that may interact with the laser.
- Clip or trim long pubic hair in the treatment area. It is not necessary to shave or trim your entire pubic region if this is not your typical practice.
- Remove any intra-vaginal appliance, i.e. estrogen ring, diaphragm, menstrual cup, or piercings to arriving to the office for treatment.
- It is recommended you wear cotton underwear and loose fitting pants to your appointment. You may want to bring a panty liner of your choice, or we can provide one to you.

External POST Treatment

- Immediately apply a cold compress or cold gel pack to the treated area for 20 minutes for any swelling or discomfort. Apply the compress for 20 minutes on then 20 minutes off as needed.
- Aquaphor will be applied prior to leaving the office.
- The skin may feel sensitive, may be red and swollen, and the treated area may be itchy.
- Gently cleanse the area 2-3 times a day with room temperature water for 7 days.
- Refrain from intimacy for at least 7 days after treatment.
- It is recommended you wear cotton underwear and loose fitting pants to your appointment. You may want to bring a panty liner of your choice, or we can provide one to you.
- Avoid wearing panty hose and tight fitting pants
- Wait 24 hours before taking a shower or bath (avoid using hot water on the area until healing is complete).