Patient Information

First and Last Name: _____

D.O.B.: _____/_____/_____

Phone / Mobile_____

Health Questionnaire:

Have you today or in the past experienced any of the following:

Active/ Chronic conditions:	Y ☐ N ☐	Specify: _____
Surgeries/ Hospitalization:	Y ☐ N ☐	Specify: _____
Medication Care:	Y ☐ N ☐	Specify: _____
Sensitivity to Medication:	Y ☐ N ☐	Specify: _____
Allergy:	Y ☐ N ☐	Specify: _____
Pregnancy:	Y ☐ N ☐	
Under age of 18	Y ☐ N ☐	

Exclusion Criteria from treatment (Contraindications):

Tick any of the boxes that apply to you:

☐ Cardiac pacemaker, defibrillator, or other implanted electronic device

Any diseases which may be stimulated by light or heat (such as Herpes Simplex)

Impaired immune system (such as HIV) or use of immunosuppressive medications

Sunburns, exposure to sun or artificial tanning during the past 3-4 weeks prior to treatment

Hepatitis or liver disease

History of bleeding coagulopathies, or use of anticoagulants (blood thinning medications)

High or low blood pressure (with medications)

Epilepsy

Hormonal disorders or endocrine disorders (such as polycystic ovary syndrome or diabetes), unless under control

Suffering from Keloid scars or impaired wound healing

☐ Vitiligo or tendency to hypopigmentation

☐ Current or history of cancer, any cancer drug therapy (such as Ducabaxine, Fluorouracil, Methotrexate, etc.), pre-cancerous lesions or problematic moles

☐ History of local or recurrent skin infection

☐ Fragile, extra dry and sensitive skin

☐ Any active skin disease or inflammation (such as Herpes, Psoriasis, Eczema, rash) the treatment area

☐ Metal implants in the treatment area

☐ Undiagnosed lesions in the treatment area

☐ History or current tattoo or permanent makeup or nevi present in the treatment area

☐ Use of Accutane (Isotretinoin, Roaccutane) within the past 3-6 months

☐ Breast-feeding

☐ Use of photosensitive medication or herbs within 2 weeks prior to treatment (such as Isotretinoin, tetracycline, or St. John's Wort.)

☐ Tretinoin – Retin A in the last 2 weeks

☐ Any synthetic filler procedures (i.e. silicon) in the treatment area. Please note that some of the fillers are "heat resistant". In these cases, treatments may start two weeks after the filler procedure.

☐ Botox injections in the past 5-7 days

☐ Chemical peel or natural fillers in the past 2 weeks

☐ Deep chemical peel / laser peel in the past 6 months

Contraindications should be thoroughly evaluated and confirmed at each patient's visit.

- For patients with chronic herpes simplex virus infections, pretreatment with antiviral medications should be initiated, especially when lesions appear in the site to be treated. Antiviral treatment typically begins 1 day prior to treatment and continues for a total of 5-7 days.

1. I _____duly authorize_____, and other specially trained personnel of this facility, to perform treatment using light based technology systems from Viora.
2. I am hereby undertaking the responsibility of the treatment outcome.
3. I hereby commit to inform about any change in my medical and health condition.
4. I do not suffer from Herpes / I suffer from Herpes and I agree to initiate preventive treatment with antiviral medications, though I am aware that preventive treatment does not ensure total prevention of Herpes appearance during the treatment.
5. I understand the procedure is purely elective and that studies indicate that results vary with each individual according to skin condition and physiological attributes as well as the medical condition of the client.
6. I understand that a commitment to a series of treatments is required to achieve optimal results and I am aware that the treatment may be performed by different Viora's personnel.
7. I consent that Viora's clinical department may discontinue the treatment course at any time without prior notice.
8. I consent to photographs for the purpose of monitoring response to treatment and for use in medical education research of Viora and the local distributor as long as my anonymity is maintained and my privacy protected.
9. I hereby declare that I was informed in regards to the following:

9.1 The versatile treatments available with Viora's light based systems are based on a principle called selective photothermolysis. The light emitted and absorbed by targeted chromophores (light sensitive molecules) encourages a specific biological process to achieve the desired clinical result.

9.2 I have been advised in regards to possible risks and side effects of the treatment which may include slight pain, erythema, edema, color changes (hyper or hypo pigmentation), paradoxical unwanted hair growth and burns. All side effects are transient and mild, however in the event of adverse side effects the treating personnel must be informed and a physician consult may be necessary.

9.3 I am aware that exposure to sun 3-4 weeks prior and after treatment are contraindicated to the treatment and may promote side effects. I was advised to use SPF >30 in between treatments.

9.4 I was advised about the use of protective goggles and I agree to wear them throughout the duration of the treatment.

My questions regarding this procedure have been answered to my satisfaction. I accept all risks of treatment and agree to provide aftercare as directed by this facility.

Client's Name	**Signature**	**Date**

For patients under the age of 18:

Guardian Name	**Relation to patient**	**Signature**	**Date**

Treating personnel Declaration:

Treating personnel's Name	**Signature**	**Date**

This consent was accepted by me, after I explained to the client all of the above and I confirm that all of my explanations were understood by her/him.