Womens Own OB/GYN LLC
Hetal Gor MD, FACOG
180 Grand Avenue
Englewood, NJ, 07631
Tel: 201-541-6868
Fax: 201-541-6869
hgormd@gmail.com

Name: _____
Address: _____
Home Phone: _____ Home: _____ Cell: _____
Age: _____ Referred by: _____

Have you ever had the following?

☐ Current or history of cancer, especially malignant melanoma or recurrent non-melanoma skin cancer, or precancerous lesions such as multiple dysplastic nevi.
☐ Any active infection,
☐ Diseases which may be stimulated by light at 515 nm to 1200 nm, such as history of recurrent Herpes Simplex, Systemic Lupus Erythematosus, or Porphyria.
☐ Use of photosensitive medication and/or herbs that may cause sensitivity to 515-200 nm light exposure, such as Isotretinoin, tetracycline, or St. John's Wort.
☐ Immunosuppressive diseases, including AIDS and HIV infection, or use immunosuppressive medications.
☐ Patient history of Hormonal or endocrine disorders, such as polycystic ovary syndrome or diabetes, unless under control.
☐ History of bleeding coagulopathies, or use of anticoagulants
☐ History of keloid scarring.
☐ Very dry skin.
☐ Exposure to sun or artificial tanning during the 3-4 weeks prior to treatment.
☐ Are you pregnant? ☐ Yes ☐ No
☐ What medications are you taking (including aspirin)? _____
☐ Daily consumption of alcohol _____
☐ Allergies: _____
☐ Are you taking any herbal preparations?(St. John's Wort, etc.) _____
If yes, list _____
☐ Do you wear contact lenses? ☐ Yes ☐ No

Skin type (when exposed to the sun <u>without protection</u> for about 1 hour)
☐ always burns, never tans ☐ always burns, sometimes tans
☐ sometimes burns, sometimes tans ☐ always tans
☐ Hispanic ☐ Asian ☐ Mediterranean ☐ Middle Eastern ☐ Black

When were you last exposed to the sun (including tanning booth)? _____

Do you use chemical sun tanning lotions? _____
Are you planning a holiday in the sun? _____
Reason for visit (area to be treated) _____
Prior treatment (if any) _____

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Patient History | FemiLift

Patient name	D.O.B	Patient Reference ID

(Please answer All questions in this section)	Yes	No	Please give full details, dates, hospitals consulted etc
Are you pregnant or think you may be pregnant?			
Are you breast feeding?			
When was the date or you last menstrual cycle?			
Date of last pap smear?			
Have you ever had an abnormal pap smear?			
	Yes	No	If “yes” please give full details, dates, hospitals consulted etc
Have you recently had any gynecological treatments or surgery?			
Do you have implanted mesh or a sling for stress urinary incontinence?			
Are you using aspirin or any blood thinning medication?			
Do you have any general medical history? (eg Epilepsy, Diabetes, Hypertension, Pregnancy)			
Do you have any type of immune deficiency? (eg HIV or Hepatitis)			
Do you have any allergies?			
Do you have any Hormone abnormalities?			
Do you take any prescribed or non prescribed medication or herbal remedies? (eg St Johns war)			

Patient Signature:	Print Name:	Date:
Practitioner Signature:	Print Name:	Date:

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FemiLift | Initial Consultation

Patient Name	Date	D.O.B
Patient Reference ID		

Consultation Notes

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I _____ voluntarily request the _____ minimally invasive procedure.

I voluntarily consent and authorize that this minimally invasive procedure to be performed by _____.

I hereby release this clinic, its staff, and any other participating health care providers from any and all liability for any adverse effects that may result from this treatment and related procedures.

For the purpose of accurate record keeping in connection with the care and treatment which I am receiving and will subsequently receive from this clinic, I, the undersigned, consent to have this clinic's staff take before, during, and after treatment close-up photographs of the involved area (s) and the anatomical region surrounding the involved area (s). These photographs shall be used for medical records and shall be treated with the same confidentiality as the remainder of my record at this clinic.

I recognize that this minimally invasive procedure is not an exact science and I acknowledge that no guarantees or assurances have been made to me as to the result or cure. There are risks related to the performance of these procedures. I understand and acknowledge that the risks that may occur in connection with this particular procedure may include the following:

- Infection - Albeit rare, infection is a possibility any time a procedure is performed. I acknowledge and understand that although rare, it is possible for an infection to become a blood-borne wide spread infection.
- Blood clots in veins and lungs - Albeit extremely rare, it may be possible to develop a blood clot associated with this treatment that goes (embolizes) to the heart and/or lungs.
- Allergic reactions - Although uncommon, I could possibly develop an allergic reaction to medicines applied to the treated area and that I could possibly develop an allergic reaction to any medications that may be prescribed for me.

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- Hemorrhage and bruising - Bruising in the treated area is possible, especially if,within the last ten (10) days, I have taken aspirin or aspirin-containing products, or other medications that "thin" the blood.
- Recurrence of the lesion - I may not experience permanent results even with multiple treatments.
- Painful or unattractive scarring - Scarring is a rare complication of laser assisted treatment, but scarring is possible because the skin surface is disrupted by the laser. To minimize the chances of scarring, it is most important that I follow ***all postoperative instructions*** carefully.
- Discomfort and pain - Some discomfort will be experienced during and after the laser treatment. I give my permission for the administration of topical and/or local injection of anesthesia when and if deemed appropriate.
- Pigment changes (skin color) - During the healing process, the treated area may become either lighter or darker in color than the surrounding skin. This is usually temporary, but on a rare occasion, if may be permanent.
- Poor healing - The resultant open wound may require more than the usual one to three weeks to heal.
- Blindness and eye damage - The laser, without protective eyewear, may cause visual loss including blindness. ***It is important to keep these shields on at all times*** during the procedure and that I ***should keep my eyes closed*** in order to protect my eyes from accidental laser exposure.

I understand and acknowledge that I have been informed by means of visual aids, as well as individual discussion, that multiple treatments are often required to cause long-term results and that some patients have no results even with multiple treatments. The usual number of treatments required is two to three, but more treatments may be required.

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I have been giving an opportunity to ask questions about my condition, alternate forms of anesthesia and treatment, the procedure to be used, and the risks and hazards involved, and I believe that I have sufficient information to give the informed consent. By signing below, I certify that I have read and fully understand the contents of this document and that I have received and understand all of the disclosures referred to herein. I certify that I am a competent adult of at least 18 years of age, or that if I am a minor under the age of 18, I understand that the consent of my parent/legal guardian having legal custody will also be required before treatment.

_____ _____

Signature of Patient | Signature of Person Authorized to Consent for Patient

_____ _____

Print Name of Patient | Print Name | Relationship

_____

Date

_____

Witness

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FemiLift Procedure Record

Patient name	Patient Reference ID
Procedure Date	D.O.B

Procedure Parameters
Test Spot Location: _____ **Energy mJ/Pixel**: _____ **Power**: Medium **Mode**: Single Pulse Tolerated well: Yes/No _____ **Energy Delivered**: 45 degrees circumferentially **Energy mj/Pixel / Power / Mode** Pass #1:_____mJ / Pixel / Medium / Single Pulse Pass #2:_____mJ / Pixel / Medium / Single Pulse Pass #3:_____mJ / Pixel / Medium / Single Pulse

Side Effects / Clinical Notes
_____ _____ _____ _____ _____ _____

Checklist	Yes	No	Comments
Is the procedure effective?			
Any side effects following the patients last procedure?			
Any change in medication since last procedure?			
Additional Notes _____ _____ _____			

Signature: _____ **Date**: _____

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Date:_____

Patient: _____

Doctor: _____

Laser Operator:_____

Procedure: ☐ **Laser Resurfacing** ☐ **FemiLift**

_____

CO2 Laser: _____ ☐ **Scanner** ☐ **FemiLift HP** ☐ **CW Hand Piece**

Patient and all personnel in treatment room wearing CO2 10,600nm eyewear: Yes / No

Fitzpatrick Skin Type: I II III IV V VI

Allergies: _____ **Medications:** _____

Pre-Op Skin Care: Yes No If yes, explain_____

Anti-Viral Medication: Yes No If yes, explain_____

Parameters:

Area: ☐ **Face** ☐ **Neck** ☐ **Chest** ☐ **Hands** ☐ **Vaginal area**

Watts/mJ: _____ ***Pulse Duration:*** _____ ***Density:*** _____ ***No. of Passes:*** _____

mJ/Pixel: _____ ***Power:*** _____ ***Mode:*** _____

Notes: _____

_____

_____

_____

Signature: _____