SOUTH COAST UROGYNECOLOGY
Alinsod Institute for Aesthetic Vaginal Surgery

AESTHETIC LASER/IPL HISTORY

Date: _____

Patient Name: _____ Age: _____ Date of Birth: _____
Address: _____
_____
_____
Phone (Home):_____Phone (Work): _____
Phone (Cell): _____ Email: _____
Referring Physician: _____
Primary Care Physician: **_____**
How did you hear about us? _____
Which body area/areas or condition would you like treated? _____
_____

(For Women) are you or could you be pregnant?	**Yes _____ No _____**
(For Women) are your menstrual periods normal?	**Yes _____ No _____**
Do you have a history of Herpes I or II in the area to be treated?	**Yes _____ No _____**
Do you have a history of keloid scarring?	**Yes _____ No _____**
Have you taken Accutane or anticoagulants in the last 6 months?	**Yes _____ No _____**
Do you have any permanent make-up, implants, or tattoos?	**Yes _____ No _____**
Have you had any unprotected sun exposure, used tanning creams or tanning beds in the last 4-6 weeks?	**Yes _____ No _____**

Hair Removal in the last 6 weeks (circle one) – shaving – tweezing – waxing – depilatories

Current skin care line
_____
_____

MEDICATION HISTORY
Please list all current medications/herbs and dosages
_____
_____
_____

ALLERGIES:
_____No known allergies (**NKA**)
_____Allergies and Reactions to medication, foods, latex, other:
_____
_____

PAST SURGERIES OR HOSPITALIZATIONS
Please list with date:
_____
_____

PAST MEDICAL HISTORY/REVIEW OF SYSTEMS (other current health problems):
Are you under a doctor's care? Yes_____ No_____ If yes, Describe _____
_____

Do you now have or have you ever had:

Neurologic (seizures, headaches, weakness, paralysis) problems?	Yes _____ No _____
Psychiatric problems?	Yes _____ No _____
Depression?	Yes _____ No _____
Head/Ear/Eyes/Nose/Throat Problems?	Yes _____ No _____
Thyroid problems?	Yes _____ No _____
Cardiac (heart) problems?	Yes _____ No _____
Lung Problems?	Yes _____ No _____
Breast Problem?	Yes _____ No _____
Gastrointestinal (stomach) problems?	Yes _____ No _____
Kidney or bladder disease?	Yes _____ No _____
Liver problems?	Yes _____ No _____
Kidney problems?	Yes _____ No _____
Hematologic (bleeding, anemia) bleeding problems?	Yes _____ No _____
Diabetes (insulin dependent/oral medication)?	Yes _____ No _____
Musculoskeletal (bones, joints, muscles) problems?	Yes _____ No _____
Circulation problems (varicose veins, thrombosis)?	Yes _____ No _____
Cancer? Type _____	Yes _____ No _____
High Blood Pressure?	Yes _____ No _____

Other Problems _____
_____

FAMILY HISTORY (check illness which has occurred in any blood relative and write relationship to you):
____ Cancer _____
____ Bleeding Disorder _____
____ Heart disease _____
____ Diabetes _____
____ Others _____

SOCIAL HISTORY
Marital status: S M W D Occupation_____
Tobacco use: Yes _____ No _____ If yes, daily amount _____ Number of years_____
Alcohol use: Yes _____ No _____ If yes, daily amount _____ Drug use: _____
Caffeine Use: Yes _____ No _____ If yes, daily amount _____
Abuse: Yes _____ No _____ If yes, describe_____
Other:_____
_____

Physical Exam:

Impression:

Plan:

SIGNATURE _____ **DATE** _____

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UROGYNECOLOGY

SKIN TYPING WORKSHEET

Client Name: _____ Date: _____

Score: _____

		0	1	2	3	4
	What is your eye color?	Light blue or gray	Blue or green	Hazel, Light brown	Dark brown	Brownish black
	What is the natural color of your hair?	Red, Sandy red	Blonde	Dark blonde, chestnut, Brown	Dark brown	Black
	What is the color of your skin (unexposed areas)?	Reddish	Very pale	Pale with beige tint	Light brown	Dark brown
	Do you have freckles on sun-exposed areas?	Many	Several	Few	Incidental	None
	What happens when you stay in the sun too long?	Painful redness, blistering, peeling	Blistering, followed by peeling	Burns, sometimes followed by peeling	Rarely burns	Never had burns
	To what degree do you turn brown?	Hardly any or not at all	Light tan	Reasonable tan	Tan very easily	Turn dark brown quickly
	Do you turn brown several hours after sun exposure?	Never	Seldom	Sometimes	Often	Always
	How does your face respond to the sun?	Very sensitive	Sensitive	Normal	Very resistant	Never had a problem
	When did you last expose yourself to the sun, tanning bed or self-tanning creams?	More than 3 months ago	2-3 months ago	1-2 months ago	Less than 1 month ago	Less than 2 weeks ago
	How often is the area you want to have treated exposed to the sun?	Never	Hardly ever	Sometimes	Often	Always

Add above column for Total Score:	Match your total score with the corresponding skin type.	Fitzpatrick Skin Type
	0-7	I
	8-16	II
	17-25	III
	26-30	IV
	Over 30	V-VI

SOUTH COAST
UROGYNECOLOGY

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REFUND POLICY

Dr. Alinsod is the leading surgeons in his field of expertise and takes great pride providing quality and confidential care. Patients are exceptionally valued and provided extensive consultation time with both Dr. Alinsod and our patient liaison, enabling all questions and concerns to be addressed well in advance of scheduled procedures and treatments.

As you can imagine, surgical slots are at a premium. A great deal of thought has been given for your evaluation, preparation, surgery time, and staffing needed for each procedure. In consideration for Dr. Alinsod's time, staff members, and fellow clients, we have an unwavering financial policy.

A 50% deposit is required at the time of scheduling surgery. This allows us to block the time needed for your procedure. The remaining balance is due one week prior to surgery. All fees must be received one week prior to surgery. A non-refundable 25% of deposit will be retained for a cancelled surgery that is not rescheduled with Dr. Alinsod.

We accept cash, all major credit cards, and cashiers' checks. Personal checks are not accepted. We provide several financing options and would be happy to discuss those with you.

Please note, additional procedures cannot be added on the day of procedure unless payment in full has been received.

Sincerely,

Red M. Alinsod, M.D., FACOG, FACS, ACGE
Urogynecology & Reconstructive Pelvic Surgery

I agree and understand the SCU Payment Policy for Aesthetic Procedures

_____ _____
Patient Signature Date

_____ _____
Patient Name (Please Print) SCU Representative