LIFE STUDIOS

MonaLisa Touch

Medical History

Client Name: _____ D.O.B: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Telephone: Home: _____ Work: _____ Cell: _____

Family Doctor: _____ Phone: _____

Pharmacy: _____ Phone: _____

_____

Emergency Contact: _____ Phone: _____

Please answer all of the following questions	**YES**	**NO**
Have you had a pap smear within the last 3 years? - if yes, what year? _____	☐ YES	☐ NO
Are you pregnant or within 3 months post-partum?	☐ YES	☐ NO
Have you experienced a vaginal or vulvar infection within the last week? (Herpes, Candida, HPV, or STD's)	☐ YES	☐ NO
Do you have a history of herpes?	☐ YES	☐ NO
- If yes, was a prescription started 48 hours before this procedure?	☐ YES	☐ NO
Do you have vaginal or cervical lesions in the treatment area that have not been evaluated and diagnosed?	☐ YES	☐ NO
Do you have a history of radiation to the vaginal or colo-rectal tissue? - If yes, what year? _____	☐ YES	☐ NO
Do you have a history of reconstructive pelvic surgery with "mesh kit"? - If yes, what year? _____	☐ YES	☐ NO
Do you have a prolapse beyond the hymen?	☐ YES	☐ NO
Do you have a history of impaired wound healing (a wound that doesn't heal correctly)?	☐ YES	☐ NO
Do you have a history of keloid formation (a raised formation of scar tissue)?	☐ YES	☐ NO
Any known anticoagulation treatment or thromboembolic condition? (Managed blood thinners such as Warfarin or Coumadin, any blood clot disorders)	☐ YES	☐ NO

I certify that the information above is accurate. I understand that withholding of information or giving false information will result in unwanted side effects. I have also been given the opportunity to ask questions and understand the information provided.

Signed: _____ Date: _____

LIFE STUDIOS

MonaLisa Touch®

Informed Consent for Internal Treatment

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

Therapy using the MonaLisa 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 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 results 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 minutes to complete. The possible associated side effects following this procedure may include vaginal spotting, mild vaginal bleeding, pink or brown vaginal discharge, mild to profuse watery vaginal discharge, irritation, burning upon urination, and discomfort.

I may be instructed by my clinician to refrain from strenuous exercise and sexual activity for 2 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.

Signed: _____ Date: _____
(Patient or person authorized to consent for the patient)

Witness: _____ Date: _____

LIFE STUDIOS

MonaLisa Touch®

Informed Consent for External Treatment

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

Therapy using the MonaLisa Touch™ Laser is an appropriate treatment for vulvar symptoms.

The laser produces small columns of damage in the soft tissue of the vulva. These columns help stimulate new collagen production which helps promote vulvar 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 results 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 treatment. The treatment takes about 15-20 minutes to complete. The possible associated side effects following this procedure may include redness, swelling, inflammation, tenderness, itching, irritation, burning upon urination, pinpoint bleeding and discomfort.

I should refrain from strenuous exercise and sexual activity for 7 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.

Signed: _____ Date: _____
(Patient or person authorized to consent for the patient)

Witness: _____ Date: _____