Pandora
FAMILY MEDICINE

6300 Baltimore Avenue
University Park, MD 20782
Phone: 301-200-0960
Fax: 877-673-1365
pandoramedicine@gmail.com

Patient Name: _____ **DOB** _____

Gender: ☐ **Male** ☐ **Female**

Current Medications: _____

Allergies: _____

Medical Conditions / Other Considerations: _____

2.1.2 Skin Type Assessment

Fitzpatrick Skin Type (last exposed to UV): **I** **II** **III** **IV** **V** **VI** **Self-Tanning Lotion:** ☐ **Yes** ☐ **No**

Passive Tan (sun or tanning bed): ☐ **Yes** ☐ **No** **Ethnicity:** _____

2.1.3 Hair Assessment

Areas to be Treated: _____ **Hair Density:** ☐ **Sparse** ☐ **Medium** ☐ **Dense**

Hair Color: _____ **Hair Thickness:** ☐ **Fine** ☐ **Medium** ☐ **Coarse**

2.1.4 Medical Questionnaire - Identifying Contraindications

Active Skin Infection (e.g., Psoriasis, Eczema): ☐ Yes ☐ No

Current or History of Skin Cancer / Other Cancer / Pre-malignant Moles / Suspicious Lesions: ☐ Yes ☐ No

Diseases Stimulated by Light (e.g., Lupus, Porphyria, Epilepsy): ☐ Yes ☐ No

Intra-Dermal or Superficial Sub-Dermal Injections / Fillers / Grafts: ☐ Yes ☐ No

Facial Laser Resurfacing / Deep Chemical Peeling (last 3 months): ☐ Yes ☐ No

Diseases Stimulated by Heat (e.g., Herpes Simplex): ☐ Yes ☐ No

Needle Epilation, Waxing, or Tweezing (last 6 weeks): ☐ Yes ☐ No

Skin Disorders / Conditions (e.g., Keloids, Abnormal Wound Healing, Vitiligo): _____

Tanned Skin: ☐ Yes ☐ No

Endocrine Disorders (e.g., Diabetes, PCOS): ☐ Yes ☐ No

Severe Concurrent Medical Conditions (e.g., Cardiac Disorders): ☐ Yes ☐ No

Use of Medication / Herbs Inducing Photosensitivity: ☐ Yes ☐ No

Saphenous Insufficiency / Severe Varicosity: ☐ Yes ☐ No

History of Bleeding Disorders:☐ Yes ☐ No

Tattoo or Permanent Makeup: ☐ Yes ☐ No

Current or Past History of Gold Therapy: ☐ Yes ☐ No

Metal Implants: ☐ Yes ☐ No

Pacemaker / Defibrillator: ☐ Yes ☐ No

Pregnancy or Nursing: ☐ Yes ☐ No

Impaired Immune System: ☐ Yes ☐ No

Notes:

Revised and Finalized on August 27th, 2025.

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Patient Name: _____

Treatment Sites: _____

Skin Type: I II III IV V VI

Date	Applicator	Treatment Area/Lesions	Optical Fluence	Pulse Type	Cooling	Repeat Mode	Notes (# passes, # pulses, Time, Skin response, etc)

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Lumecca Consent Form

Patient Name: _____

Treatment Sites: _____

I, DULY AUTHORIZE _____ to perform _____treatment.

I understand that the device being used for Laser Hair Removal, Vascular Lesion Clearance, Skin Rejuvenation, Fractional Skin Resurfacing, Skin Tightening, of which I am consenting to be a patient receiving _____ treatment (specify procedure).

I understand that clinical results may vary depending on individual factors, including but not limited to medical history, skin type, patient compliance with pre- and post-treatment instructions, and individual response to treatment.

I understand that there is a possibility of short-term effects such as reddening, mild burning, temporary bruising and temporary discoloration of the skin, as well as the possibility of rare side effects such as scarring and permanent discoloration. These effects have been fully explained to me _____ (patient's initials).

I understand that treatment with this system involves a series of treatments and the fee structure has been fully explained to me _____ (patient's initials).

I certify that I have been fully informed of the nature and purpose of the procedure. expected outcomes and possible complications. and I understand that no guarantee can be given as to the final result obtained. I am fully aware that my condition is of cosmetic concern and that the decision to proceed is based solely on my expressed desire to do so. I confirm that I have informed the staff regarding any current or past medical condition, disease or medication taken.

I consent to the taking of photographs and authorize their anonymous use for the purposes of medical audit, education and promotion.

I certify that I have been given the opportunity to ask questions and that I have read and fully understand the contents of this consent form.

Patient Signature: _____

Date: _____

Witness: _____