SenzaPeloMedSpa

Professionalism, Dedication, Kindness And Compassion

CLIENT PROFILE

Legal Name: _____ _____DOB: _____ _____Gender: _____

Preferred Name:_____ Address: _____

City: _____ State: _____ Zip: _____

Primary Phone: (_____) _____--_____ Secondary Phone: (_____) _____--_____

E-mail Address (please print): _____

Who shall we thank for the referral?_____

In what services are you interested? __ Electrolysis __ Laser Hair Removal __ Electrodesiccation (blemish removal)

__ Aesthetic Nursing ((fillers & relaxers) __ Laser Rejuvenation __ Aesthetics __ IM Injections __ Permanent Makeup

Please Circle ALL "yes/no"

Would you like to receive our exclusive e-mail and text message promotions? (Please circle) YES NO

Medical Skin History

1. Do you have any permanent make-up or tattoos? **YES** **NO** Explain: _____
2. Have you recently prolonged sun exposure or artificial tanning within last four weeks *(all areas)*? **YES** **NO**
3. Are you currently using Retin-A/ Bleaching Agents? YES NO If yes, where was it applied?_____
4. Are you currently using or have you ever used Photosensitive medication such as Accutane? **YES** **NO**
   If yes, explain_____
5. Have you ever had microdermabrasion or chemical peel? **YES** **NO** If yes, how long ago? _____
6. Have you recently had facial surgery or laser resurfacing? **YES** NO If yes, how long ago? _____
7. Do you smoke? YES NO
8. Do you get cold sores/fever blisters? **YES** **NO** If yes, last breakout? _____
9. Are you sensitive to alcohol-based products? **YES** **NO**
10. List any items you are allergic/sensitive to: _____
11. Are you taking any other medications/ supplements/vitamins at this time? **YES** **NO**
    If yes, please list:

    _____
12. Do you have any medical conditions or autoimmune disorders? **YES** **NO**
    If yes, explain_____
13. Upcoming medical procedures **YES** **NO**

Medical Hair History

Area(s) to be treated:_____

_____

1. Are you pregnant? **YES** **NO** Are you lactating? **YES** **NO**
2. Are you in or past menopause? **YES** **NO**
3. Do other family members have excessive hair? **YES** **NO** Relationship _____
4. Please list previous/current methods of hair removal _____
   How often are you using hair removal: _____ Last time you removed your unwanted hair _____
5. List previous laser/electrolysis treatments: First treat. date: _____ Last treat. date _____
   Electrolysis modality: Thermolysis _____ Blend _____ Galvanic _____Laser Type

_____

Patient Signature: _____Date:_____

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PATIENT MEDICAL CONSENT FORM:
DERMAL FILLERS

Treatment with Collagen or Restylane can smooth out folds and wrinkles, add volume to the lips, and contour facial features that have lost their fullness due to aging, sun exposure, illness, etc. Facial rejuvenation can be carried out with minimal complications. Restylane and Collagen are injected into the skin with a very fine needle. The products produce a natural volume under the wrinkle, which is lifted up and smoothed out. The results can often be seen immediately. Treating wrinkles with Restylane or Collagen is fast, safe, and leaves no scars or other traces on the face.

Risks and Complications

It has been explained to me that there are certain inherent and potential risks and side effects in any invasive procedure, and in this specific instance, such risks include but are not limited to: 1) post- treatment discomfort, swelling, redness, and bruising or discoloration; 2) post-treatment infection associated with any transcutaneous injection; 3) allergic reaction (Collagen); 4) reactivation of Herpes (cold sores); 5) lumpiness, visible yellow or white patches in approximately 20% of cases; 6) granuloma formation; 7) localized necrosis and/or sloughing (with scab and/or without scab), if blood vessel occlusion occurs.

Photographs

I authorize the taking of clinical photographs and their use for scientific purposes both in publications and presentations. I understand my identity will be protected.

Pregnancy, Allergies and Disease

I am not aware that I am pregnant. I am not trying to get pregnant. I am not lactating (nursing). I do not have or have not had any major illnesses which would prohibit me from receiving Collagen or Restylane. If I am receiving Zyderm®/Zyplast® or Cosmoderm™/Cosmoplast™, I certify that I do not have multiple allergies or high sensitivity to medications, including, but not limited to, Lidocaine.

Payment

I understand that this procedure is cosmetic and that payment is my responsibility.

Leftover Product

You may opt to save a partial syringe to use after the initial swelling goes away, but it will be discarded if not used within three weeks. *Initials*_____

If you opt to save a partial syringe, we can save it here at the office for up to three weeks. After that it will be discarded. There is a $35.00 appointment fee to inject the remainder of the syringe.

Initials _____

Results

I am aware that full correction is important and that follow-up touch-ups/treatments will be needed to maintain the full effects. I am aware that the duration of treatment is dependent upon many factors including, but not limited to, age, sex, tissue condition, my general health and lifestyle conditions, and sun exposure. The correction, depending upon these factors, may last 3-6 months and in some cases longer. I have been instructed in and understand post-treatment instructions and have been given a copy of them.

I understand the information on this form is essential to determine my medical and cosmetic needs and the provision of treatment. I understand that if any changes occur in my medical history/health I will report it to the office as soon as possible. I have read and understand the above medical history questionnaire. I acknowledge that all answers have been recorded truthfully and will not hold any staff member responsible for any errors or omissions that I have made in the completion of this form.

- ❑ **I hereby voluntarily consent to treatment. The procedure(s) has been explained to me. I have read the above and understand it. My questions have been answered satisfactorily. I accept the risks and complications of the procedure. I certify that if I have any changes occurring in my medical history, I will notify the office.**

Patient Signature: _____ Date: _____

Registered Nurse Signature: _____ Date: _____

JUVÉDERM VOLUMA® XC and JUVÉDERM® XC Important Information

APPROVED USES
JUVÉDERM VOLUMA® XC injectable gel is for deep injection in the cheek area to correct age-related volume loss in adults over 21.

JUVÉDERM XC® injectable gel is for injection into the facial tissue for the correction of moderate to severe facial wrinkles and folds, such as nasolabial folds.

IMPORTANT SAFETY INFORMATION

Are there any reasons why I should not receive any JUVÉDERM® injectable gel formulation?
Do not use these products if you have a history of multiple severe allergies or severe allergic reaction (anaphylaxis), or if you are allergic to lidocaine or the gram-positive bacterial proteins used in these products.

What precaution should my doctor advice me about?

- Tell your doctor if you are pregnant or breastfeeding. The safety of these products for use during pregnancy or while breastfeeding has not been studied
- The safety of JUVÉDERM® XC injectable gels in patients under 18 years, and the safety of JUVÉDERM VOLUMA® XC in patients under 35 years or over 65 years has not been studied
- The safety and effectiveness of JUVÉDERM® XC for areas other than facial wrinkles and folds have not been established in clinical studies.
- Tell your doctor if you have a history of excessive scarring (eg, hypertrophic scarring and keloid formations) or pigmentation disorders, as use of these products may result in additional scars or changes in pigmentation
- Tell your doctor if you are planning other laser treatments or a chemical peel, as there is a possible risk of inflammation at the treatment site if these procedures are performed after treatment
- Patients who experience skin injury near the site of injection with these products may be at a higher risk for side effects
- Tell your doctor if you are on immunosuppressive therapy used to decrease the body's immune response, as use of these products may result in an increased risk of infection
- Tell your doctor if you are using medications that can prolong bleeding, such as aspirin, ibuprofen, or other blood thinners, as this may result in increased bruising or bleeding at the injection site
- Minimize strenuous exercise, exposure to extensive sun or heat, and alcoholic beverages within the first 24 hours following treatment

What are possible side effects?
The most common side effects include tenderness, swelling, firmness, lumps/bumps, bruising, pain, redness, discoloration, and itching. With JUVÉDERM® XC injectable gels, most side effects are mild or moderate and last 14 days or less. For JUVÉDERM VOLUMA® XC, side effects are moderate (uncomfortable) and last 2 to 4 weeks.

One of the risks with using this product is unintentional injection into a blood vessel, and while rare, the complications can be serious and may be permanent. These complications , which have been reported for facial injections, can include vision abnormalities, blindness, stroke, temporary scabs, or permanent scarring.
As with all skin injection procedures, there is a risk of infection.
To report a side effect with JUVÉDERM VOLUMA® XC or JUVÉDERM® XC, please call Allergan Product Surveillance at **1-800-624-4261.**

For more information, please see Juvederm.com or call Allergan Medical Information at 1-800-433-8871.
Available by prescription only.