PATIENT MEDICAL QUESTIONNAIRE FORM

BodiSnatcher Studio LLC

To provide you with the most appropriate treatment, we need you to complete the following questionnaire.
All information is strictly confidential.

Full Name: _____ Date: _____

Age: _____ Date of Birth: _____/_____/_____ Gender: M F

Address: _____

City: _____ State: _____ Zip: _____

Mobile Number: _____ Other Number: _____

E-mail: _____

How did you hear about us? _____

In case of emergency, whom should we contact? _____ Phone: _____

Medical History

Are you currently under the care of a physician? ☐ Yes ☐ No

If yes, for what: _____

Are you currently under the care of a dermatologist? ☐ Yes ☐ No

If yes, for what: _____

Do you have a history of erythema abigne, which is a persistent skin rash produced by prolonged or repeated exposure to moderately intense heat or infrared irritation? ☐ Yes ☐ No

Have you ever had the following? (Please check all that apply)

☐ Heart disease	☐ Cancer	☐ Eye conditions
☐ Heart attack/chest pain	☐ Endocrine/hormone	☐ Epilepsy/Seizures
☐ Thyroid imbalance	☐ Easy bleeding/bruising	☐ HIV or AIDS
☐ Hypertension	☐ Frequent cold sores	☐ Abnormal wound healing
☐ Herpes	☐ Hepatitis	☐ Blood clotting abnormalities
☐ Currently pregnant	☐ Pacemaker	☐ Keloid scarring
☐ Eczema/Psoriasis	☐ Diabetes	

☐ Other (including any active infections):

_____

List any active medical conditions: _____

List any current medications: _____

List any allergies: □ Lidocaine □ Hydrocortisone □ Hydroquinone or skin bleaching agents □ Others:

_____

Do you have hyperpigmentation (darkening of the skin), hypopigmentation (lightening of the skin) , or marks after physical trauma? □ Yes □ No; If yes, please describe: _____

For our female clients:

- Are you pregnant or trying to become pregnant? □Yes □No
- Are you breastfeeding? □Yes □No
- Are you using contraception? □Yes □No
- Regular Periods? □ Yes □No
- Post Menopause? □Yes □ No

MEDICATIONS

What oral medications are you presently taking? □ Birth control pills □ Hormones

Others (Please list all) _____

Supplements? _____

-Have you ever used Accutane? □Yes □No; If yes, when did you last use it? _____

-What topical medications or creams have you used in the last 2 weeks or are you currently using?

□Retin-A® □Others (Please list): _____

Any tattoos or permanent makeup? (Explain Where)

_____

Dermatologic History Have you ever had (please check all that apply)

□ Chronic skin conditions □ Skin cancer □ Laser skin resurfacing

□ Chemical Peel □ Electrolysis/threading □ Herpes simplex/cold sores

□ Keloid/hypertrophic scarring □ Accutane □ Botox® injection

□ Pigmentation disorder □ Tetracycline □ Injection of collagen/filler

□ Recent waxing/plucking □ Photosensitivity

□ Recent sunburn/tan (include tanning bed)

What is your ethnic background? _____

Which of the following best describes your skin type?

(Please circle one number)

I	Always burn, never tans.
II	Always burns, sometimes tans.
III	Sometimes burns, always tans.
IV	Rarely burns, always tans.
V	Brown, moderately pigmented skin
VI	Black skin

Do you regularly use tanning salons or sunbathe? YES / NO How often? _____

When exposed to the sun, do you usually:

□ Always burn, never tan □ Burn easily, tan poorly
□ Burn minimally, tan easily □ Rarely burns, tan easily □ Never burn

Do you use sunscreen regularly? _____ Do you use artificial or "sunless" tanning products? _____

I certify that the preceding medical, personal, and skin history statements are true and correct. I am aware that it is my responsibility to inform the technician, esthetician, therapist, doctor, or nurse of my current medical or health conditions and to update this history. Current medical history is essential for the caregiver to execute appropriate treatment procedures.

Patient Signature: _____ Date: _____

Parent or Guardian (if Patient is under 18 years of age): _____

Informed Contraindications/Pre & Post Care Instructions:

Botulinum Type A Toxin & Derma Fillers Injections

Contraindications:

In medicine, a "contraindication" is a condition that serves as a reason not to take a certain medical treatment due to the harm that it would cause the patient. Contraindications include but may not be limited to:

- Infection at the injection site;
- Allergic reaction to any of the ingredients in the toxins (Albumin/Egg allergy) or Dysport (cow's milk protein);
- Serious preexisting disease: DM1 or DM2 (not controlled);
- CHF; uncompensated CAD, RA/SLE, etc.;
- Not currently taking any of the following medications which are contraindications to receiving Botox: aminoglycosides, nerve blockers (anticholinesterases, succinylcholine), lincosamides, polymyxins, quinidine, or magnesium sulfate.
- Blood donors (unable to donate after treatment for a period of time determined by the blood bank);
- Underage patients.
- Any diseases that affect the nerves and cause a generalized impairment of muscle strength including but not limited to Myasthenia Gravis, Multiple Sclerosis, Lambert Eaton Syndrome, Amyotrophic Lateral Sclerosis (ALS), Parkinson's.
- Pregnant or planning to become pregnant soon; or breastfeeding.

_____**(INITIAL)** These contraindications may increase the chances of side effects with treatment.

I certify that I have none of the known conditions that would contraindicate this treatment.

Pre-Care: Botulinum Type A Toxin & Fillers Injection Instructions

Please review the following information carefully to achieve optimum results from your treatment and the most comfortable recovery.

- Avoid alcoholic beverages at least 24 hours prior to treatment (alcohol may thin the blood and increases the risk of bruising).
- Avoid anti-inflammatory/blood thinning medications for a period of 2 weeks (ideally) before treatment. Medications and supplements such as Aspirin, high doses of Vitamin E, Ginkgo Biloba, St. John's Wort, Fish Oils, Garlic, Ibuprofen, Advil, Aleve, and other NSAIDS are all blood thinning medications and can increase the risk of bruising or swelling after injections.
- Schedule Toxin injections approximately 2 weeks prior to a special event such as a wedding or vacation. It is not desirable to plan a very special event and have an unforeseen bruise occur from an injection.

_____**(INITIAL)**

Post-Care: Botulinum Type A Toxin & Fillers Injection Instructions

- Do not massage any of the areas of your face that were treated with Toxin injections 3-4 hours following treatment. This could spread Toxin injections into an area of the muscle where we do not want it to migrate. However, facial exercise in the area of the treatment is recommended (frown/smile/squint 1 hour). It will encourage the Toxin injections to disperse throughout the treated muscle in a uniform manner.
- Keep your head elevated (do not lie down) for 3-4 hours after your Toxin injections treatment and avoid strenuous exercise for approximately 24 hours.
- It is not uncommon to get a small, reddened area or even a bruise at the site of injection. If this occurs and you are concerned, or if it persists, please call our office for a follow-up appointment.
- The Toxin injections will "take" several days after your treatment. This time varies from individual to individual. The average number of days for the effects to start becoming apparent is 3- 5 days. However, complete peak results will take up to 2 weeks.
- Make-up may be used as long as skin is not broken or irritated.
- Avoid strenuous exercise and alcohol for 4 hours after treatment.
- wait until 2 weeks for more Botox injections for adjustments due to the need to wait until all the Botox takes effect (which may take up to 2 weeks).
- Toxin injections will usually need to be repeated at 3–4-month intervals for several treatments to be most effective.

_____**(INITIAL)**

Patient's Printed Name: _____

Signature: _____ **Date:** _____

DERMAL FILLERS COSMETIC CONSENT FORM

I am aware that injecting dermal fillers (hyaluronic acid) for correction of wrinkles on the face and undesired folds on the facial skin carries risks and may cause complications.

This product is administered via a syringe, or injection into the area of the face sought to be filled with hyaluronic acid to eliminate or reduce wrinkles. Multiple injections might be made depending on the site, depth of deformity, and technique used. Risks and complications include but are not limited to:

Risks and Complications:

1. Facial bruising, redness, swelling, itching, and pain: These symptoms are usually mild and last less than a week but can be longer period some patients may experience additional swelling or tenderness at the implant site and rarely pustules may form. These reactions may last for a long as approximately 2 weeks, and inappropriate cases may need to be treated with oral quarter corticosteroids or other therapy. Patients who are using medications that can prolong bleeding, such as aspirin, warfarin, or certain vitamins and supplements may experience bruising or bleeding at the injection site. _____ **(Initial)**

2. Nodules, and palpable material: There is a risk of small lumps that may form under the skin, and I may be able to feel the product in the areas where it has been injected. Any foreign material injected into the body may create the possibility of swelling or other local reactions to filler material. _____ **(Initial)**

3. Unintentional injection into blood vessels: unintentional injection into these vessels can cause embolism, tissue necrosis, vision impairment, blindness and stroke. _____ **(Initial)**

4. Infection: any injection of filler materials carries the risk of infection. _____**(Initial)**

5. History of herpes infection: I understand that there is a risk that the injection of any filler material carries the risk of reoccurrence of an outbreak of herpes and that outbreak may be severe in nature. I have disclosed to the health care provider my medical history and in particular, disclose prior herpes outbreak. _____ **(Initial)**

6. Allergic reactions: I understand that dermal filler should not be used in patients with severe allergies, a history of anaphylaxis, or a history of the presence of multiple severe allergies or hypersensitivity to any of the ingredients in the filler, especially hyaluronic acid and gram-positive bacterial proteins. _____ **(Initial)**

7. Migration: I understand that filler may move from the space where it was injected. _____ **(Initial)**

8. Duration of effect: I understand that the outcome of treatment will vary among patients. In some instances, additional treatments may be necessary to achieve the desired outcome. _____ **(Initial)**

9. Concomitant dermal therapies: if you are considering laser treatment, chemical skin peeling or any other procedures based on a skin response after hyaluronic acid treatment, or you have recently had such treatments and the skin has not healed completely, there is a possible risk of an inflammatory reaction at the site. _____ **(Initial)**

10. Keloid scarring: Filler in patients with known susceptibility to keloid formation or hypertrophic scarring is not recommended.

11. Pregnancy: the safety of fillers has not been studied for use during pregnancy. _____ **(Initial)**

General:

I am undergoing treatment of my own free will. I agree that this procedure is being performed for cosmetic reasons and that no guarantee can be made as to the exact results of this procedure. I understand that precautions will be taken to prevent complications and that while complications from this procedure are rare, they can and sometimes do occur. _____**(Initials)**

I agree that this constitutes full disclosure and that it supersedes any previous verbal or written disclosures. I certify that I have read, and fully understand the above information and that I have had sufficient opportunity for discussion to have any questions answered. _____**(Initials)**

I agree for photographs to be taken before, during and after my treatment and may be used for publications and educational purposes and consent to the admittance of observers. _____**(Initials)**

My questions regarding the procedure, if any have been answered satisfactorily. I understand the procedure and accept the risks.

I CERTIFY THAT I HAVE READ THIS DOCUMENT AND I FULLY UNDERSTAND ITS CONTENT. I AM AWARE THAT THIS IS A RELEASE OF LIABILITY AND A CONTRACT AND I SIGN IT OF MY OWN FREE WILL.

Printed Name _____

Signature _____ **Date** _____