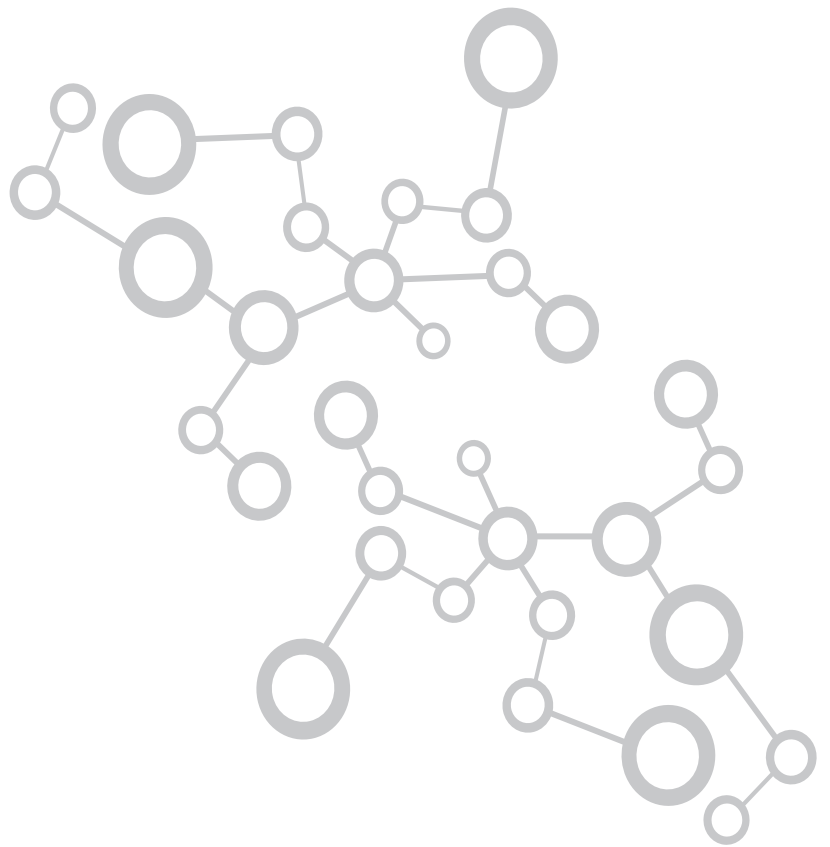




My FILLER

NEW LIFE TO THE SKIN

*Medical Questionnaire & Consent Form
Prior To Treatment*



MEDICAL QUESTIONNAIRE PRIOR TO TREATMENT

Subject to medical secrecy.

Your Details

First Name	Date of Birth
Last Name	Phone Number
Address	Email Address
Postcode	How did you hear about us?
GP's name, address and tel:	Do you use sunbeds? Yes <input type="checkbox"/> No <input type="checkbox"/>
.....	Do you smoke? Yes <input type="checkbox"/> No <input type="checkbox"/>
.....	Do you drink alcohol? Yes <input type="checkbox"/> No <input type="checkbox"/>

Medical Information

Have you suffered from any of the following? If yes, please tick

<input type="checkbox"/> Heart Disease/Angina	<input type="checkbox"/> Auto-immune disease	<input type="checkbox"/> HIV/Hepatitis
<input type="checkbox"/> High/Low Blood Pressure	<input type="checkbox"/> Stomach Ulcer/Colitis	<input type="checkbox"/> Arthritis
<input type="checkbox"/> Depression	<input type="checkbox"/> Thyroid Problems	<input type="checkbox"/> Skin disease (Acne)
<input type="checkbox"/> Glaucoma/Cataract	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Facial Cold Sores
<input type="checkbox"/> Bell's/Facial Palsy	<input type="checkbox"/> Asthma/Bronchitis	<input type="checkbox"/> Convulsion

Other

.....

Do you practice sport? Yes No if yes, please specify

Do you have a blood clotting disorder/ require anti-coagulant treatment? Yes No

Are you pregnant, planning a pregnancy or breast feeding? Yes No

Are you currently taking medication? Yes No

Have you had any surgery in the past 3 months? Yes No

Do you have any allergies? Yes No

If you have answered YES to any of the above, please provide details

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Previous Treatment

Have you already had micro-needling treatment? Yes No

Please tick? Dermapen Hyperboost Dermal Roller Other

Date of Treatment (month / year)	Treatment Areas	Name of products

INFORMATION SHEET
Before the treatment please read this document carefully

Don't hesitate to ask questions if you feel the information is not clear
Your practioner, who is trained in the treatment techniques, will be available to answer your questions
Take the time you need before making your decision

1. INFORMATION

- Results cannot be guaranteed, they depend on many factors including the skin's elasticity, the ability of the skin to heal, the number of treatments required, the type of skin you have (this differs from client to client)
- Your practioner will plan out a treatment regime for you and will take photographs of you prior to treatment commencing. By signing this document you agree to photos being taken before and after treatment
- Your practioner will discuss a course of treatments with you to suit your specific requirements
- Please be aware that certain lifestyle changes and/or ongoing skincare regimes may affect your results. Your practioner cannot be held responsible if you do not make the correct lifestyle changes or follow the advice given to get the best results.

2. PRECAUTIONS FOR USE AND CONTRAINDICATIONS

- Pregnant or breast-feeding women
- Sports persons have to be alerted on the fact that this product contains an active compound, which may lead to a positive reaction to dope testing
- History of hypersensitivity to one of the components of the products tested (hyaluronic acid, lidocaine, vitamins) or of anaphylactic shock or severe allergy.
- History of autoimmune disease or disease affecting the immune system (type 1 diabetes, polyarthritis, rheumatoid arthritis, ankylosing spondylitis, psoriasis, thyroid disorder, scleroderma, inflammatory intestinal disease, lupus, multiple sclerosis, ulcerative colitis)
- Pathology (herpes, acne, rosacea) or unhealed skin alteration
- Complications after surgery during the past 5 years
- Previous injection of permanent products (silicone, acrylic, polymers, dextran)
- Untreated infectious periodontitis, cellulitis or dental or ENT origin, dental abscess untreated or treated less than one week ago
- In association with a peeling, a laser or ultrasound treatment

3. Patch Test

My practioner has explained to me that numbing cream and the serum will be applied to my skin prior to treatment I agree to undergoing a patch test. I accept that a skin patch test will be inconclusive long-term but may determine whether I will experience a reaction to a product within 48 hours.

I confirm I have undertaken a patch test: Yes No

Print name

Signature

Date

CONSENT FORM

My practioner has explained the various treatment available to me. I understand that the treatment involves the use of tiny sterile needles which will break the surface of the skin and may cause bleeding or bruising. I hereby give written consent to the practioner named below to carry out Dermapen / Hyperboost / Hyaluron pen treatment on me as agreed in my consultation. I agree to the total cost of the treatment prior to beginning the recommended course. I understand that results cannot be guaranteed and will not pursue my practioner in any way should the results not deliver the desired outcome. I have been notified that all payments are non-refundable. I agree to complete the course of treatments recommended by the practioner and understand that results can be affected if I fail to do so.

The area to be treated is

I hereby authorise to treat me using MyFiller serums. I understand that the effects may not be 100% and that multiple treatments may be necessary to achieve the best results.

I understand that there are certain risks associated with MyFiller serum treatment. I certify that I have read the entire informed consent and I agree to all its provisions. I certify that I have had the opportunity to ask questions and those questions have been answered to my satisfaction. I fully understand the treatments conditions and procedure.

I agree to pay £ for the above-mentioned services and understand there will be no refund for any performed services. This consent form and cost covers above mentioned treatments only. Additional treatments can be added to this consent form and will be charged as per clinic price list.

I have been made aware of the risk and I accept these terms and conditions as part of my treatment. My practitioner will not accept liability for any of the above side effects. By signing, I agree to the terms and conditions and in the event of any of the above, I or any of my representatives, will not pursue the practitioner in any means of compensation.

- The objectives and methods of the treatment procedure have been clearly explained to me by the practitioner
- I have received, read and understood the information supplied by the practitioner prior to the treatment
- I have had the opportunity to ask any necessary questions
- I understand the pre and post recommendations and I agree to follow them
- I acknowledge that I had the time required for consideration and to make my decision
- I acknowledge that I have been clearly informed of the side effects
- I freely and voluntarily consent to receiving treatment

Client's Name

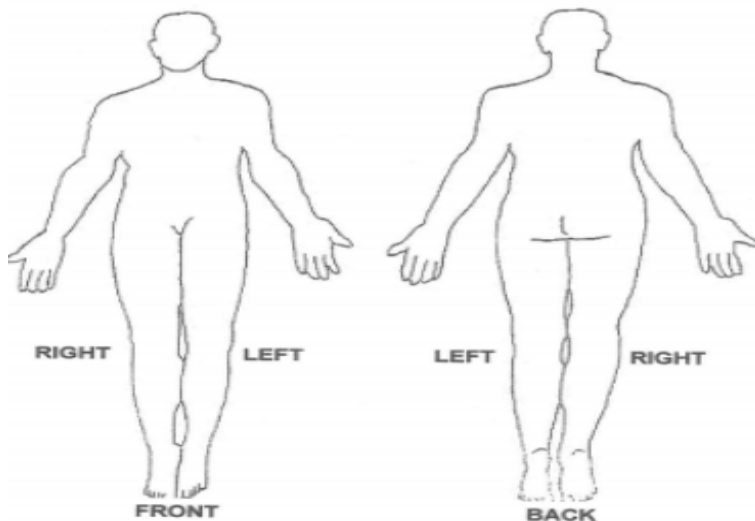
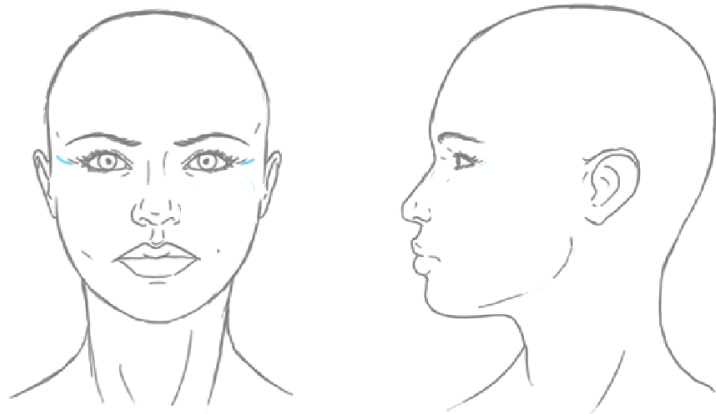
Client's Signature

Date

Practitioner Name

Practitioner Signature

Date



Treatment Area: Size of area treated (cms)

Serum used: Total volume administered

Speed of administration Numbing cream applied:

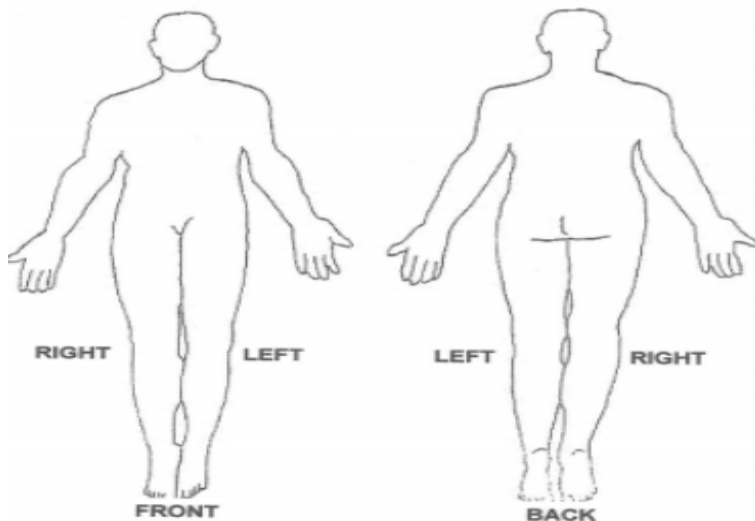
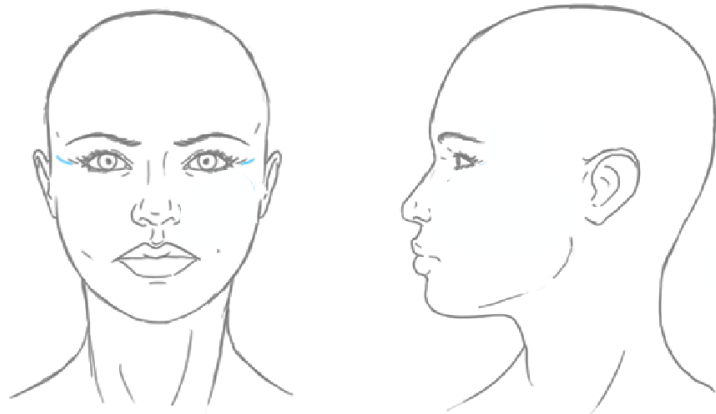
Tolerance level (1 = lowest / 10 highest) 1 2 3 4 5 6 7 8 9 10

Treatment notes

The treatment has been completed to my satisfaction and I have been given the opportunity to discuss any immediate concerns with my practioner. I fully understand the aftercare instructions and have been given written after-care information

Print name Signature Date

Practioner Signature Date of next treatment



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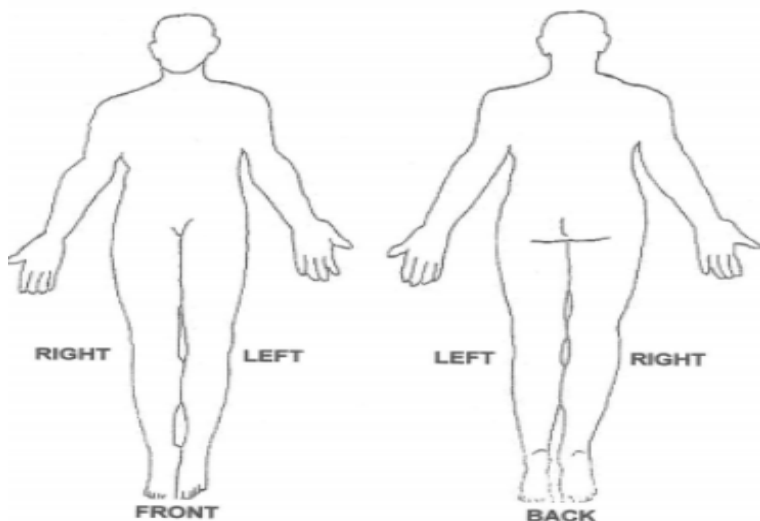
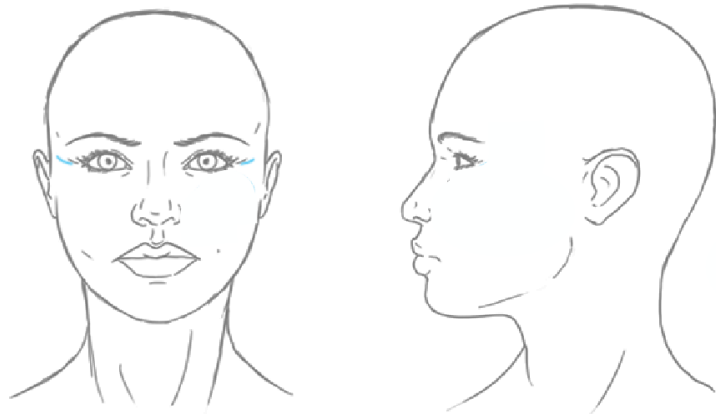
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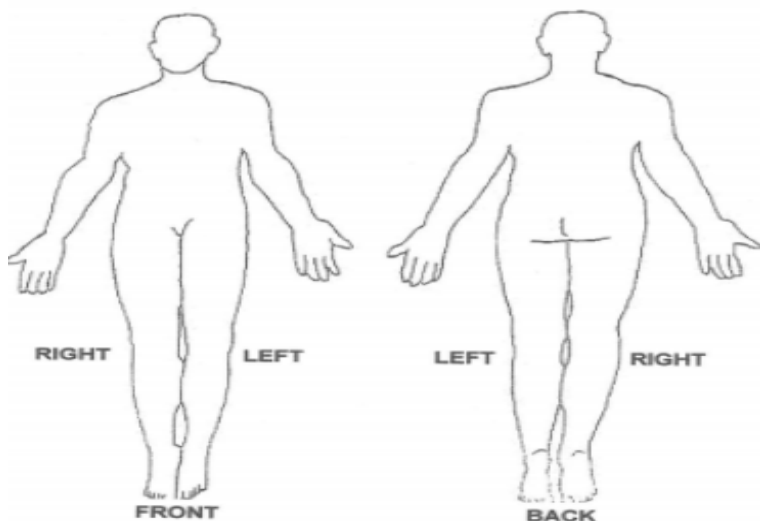
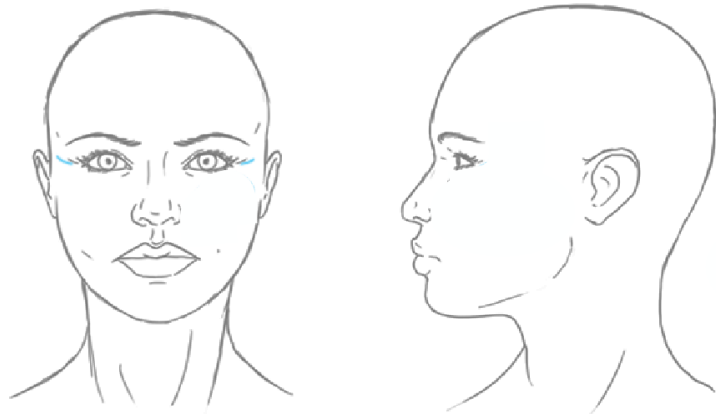
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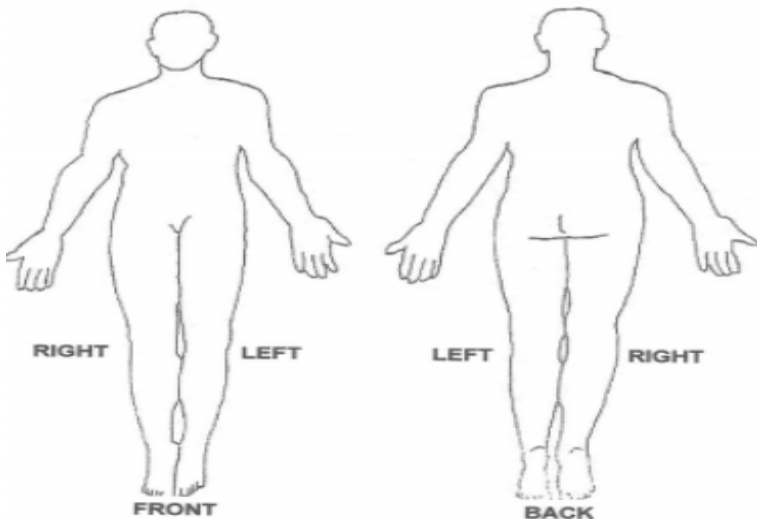
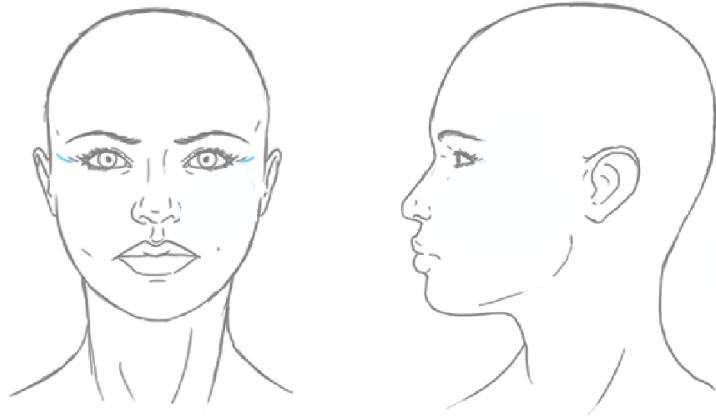
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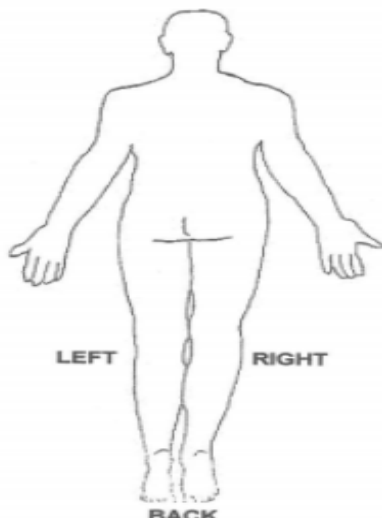
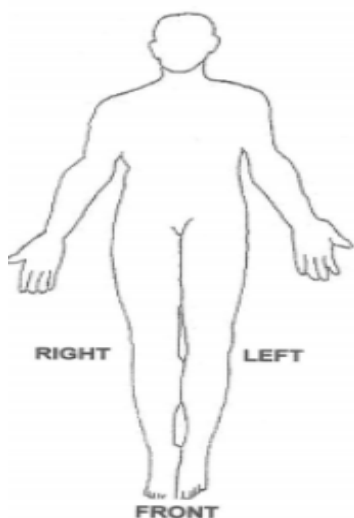
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