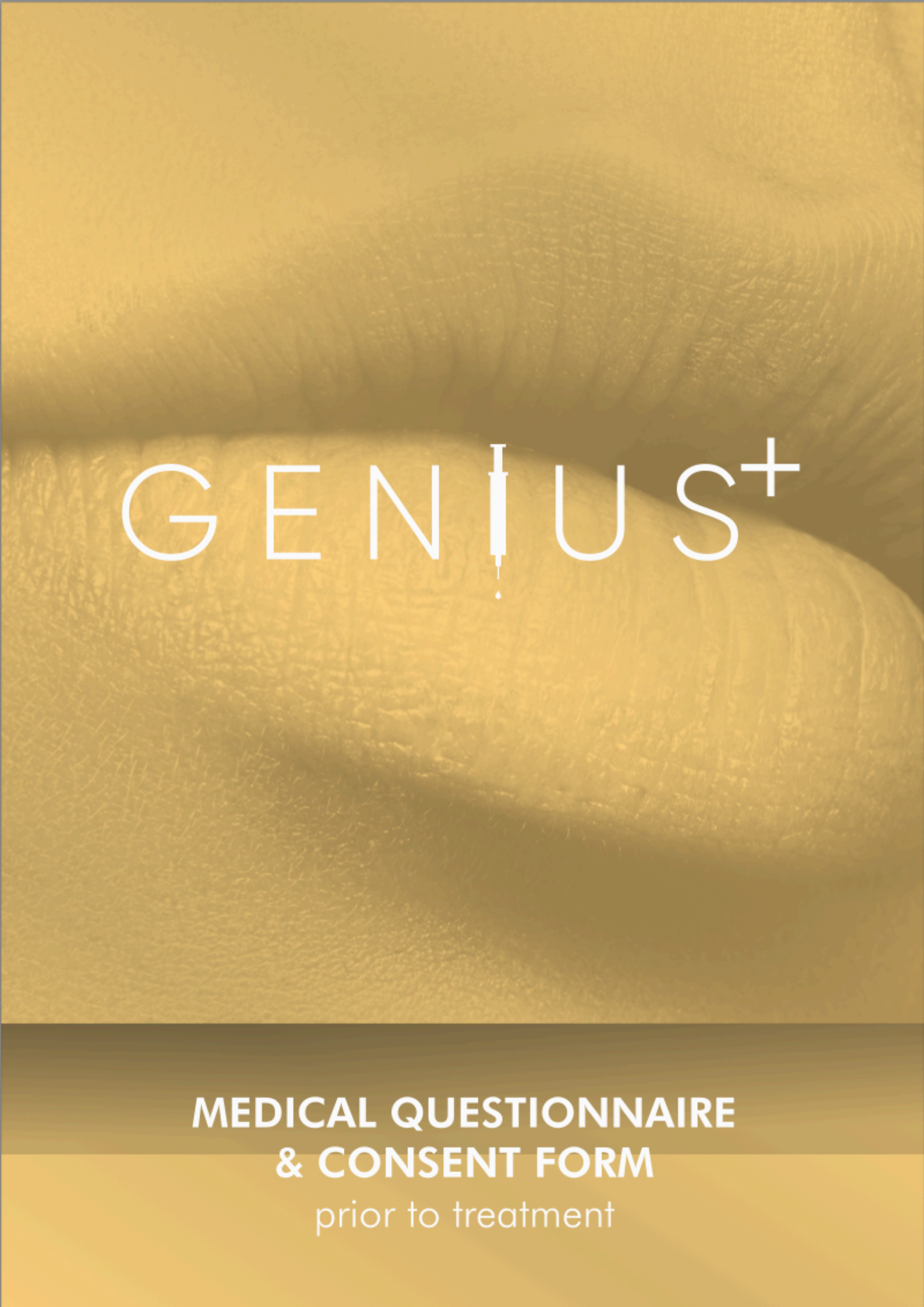

MEDICAL QUESTIONNAIRE & CONSENT FORM

prior to treatment

GENIUS+

Subject to Medical Secrecy

YOUR DETAILS

First Name .....
Surname .....
Address .....
Postcode.....
GP's Name, Address & Tel .....
.....
.....

Date of Birth .....
Phone Number .....
Email Address .....
How did you hear about us? .....
Do you use sun beds? Yes ☐ No ☐
Do you smoke? Yes ☐ No ☐
Do you drink alcohol? Yes ☐ No ☐

MEDICAL INFORMATION

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

Heart Disease/Angina ☐	Auto Immune Disease ☐	HIV/Hepatitis ☐
High/Low Blood Pressure ☐	Stomach Ulcer/Colitis ☐	Arthritis ☐
Depression ☐	Thyroid Problems ☐	Skin Disease/Acne ☐
Glaucoma/Cataract ☐	Diabetes ☐	Facial Cold Sores ☐
Bell's/Facial Palsy ☐	Asthma/Bronchitis ☐	Convulsions ☐

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 surgeries 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 .....
.....
.....

PREVIOUS TREATMENT

Have you already had aesthetic treatment? Yes ☐ No ☐
What was it with? HA Dermal Fillers ☐ Botulin Toxin ☐ Other ☐
If other, please specify .....

Date of Treatment (month/year) .....
Treatment Areas .....
.....
Name of Products .....
.....

Date of Treatment (month/year) .....
Treatment Areas .....
.....
Name of Products .....
.....

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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. PRODUCTS AND INDICATIONS

The product used includes cross-linked and non-cross-linked HA gels (cross-linking is a process which can transform a liquid gel into a viscoelastic gel) as well as gels with or without anaesthetic (lidocaine).

The product used is designed for filling wrinkles and lines, contouring the face/body, skin rejuvenation or increasing lip volume. This product has a 6 to 18 month duration, depending on several factors; skin type, the severity of the wrinkles to be corrected, the injection zone and the volume injected. Your practioner will help you choose the product for injection according to your desired results.

2. PRECAUTIONS FOR USE

- Pregnant or breast-feeding women
- Sports persons have to be alerted on the fact that this product contains an active compound which may lead a positive reaction to doping testing
- History of hypersensitivity to one of the components of the products tested (hyaluronic acid, lidocaine, vitamins) or of anaphylactic shock or serve allergy
- History of auto immune 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. CONTRAINDICATIONS

The filler used has been available commercially for many years, with several million syringes injected. Based on current data, there is no reason to suspect any unknown risks. According to international literature and health authorities, hyaluronic acid-based products may potentially have side effects. Indeed, although hyaluronic acid is a natural constant of the dermis, an injection of hyaluronic acid is likely to cause a skin reaction as if this molecule was a foreign body. These reactions are usually temporary but influenced on the one hand, by many external factors (type of product, technique, site, number of injections and quantity of product injected), on the other hand, by factors specific to the person being injected (injection tolerance, nervousness at the time of injection, medical history).

- Dissatisfaction with the expected aesthetic results
- Redness, bruising, ecchymosis, haematoma, oedema, itching, mild pain at the injection point which may occur after the injection and is resorbed after 24 hours to 8 days (on average 72 hours)
- Indurations or nodules which may occur at the injection point 15 days to 3 months after the injection
- Discolouration of the injection zone

I have also been informed that rare cases of medical device vigilance have been described in the literature, necrosis in the glabellar region, abscess, granuloma and hypersensitivity following injections of hyaluronic acid, however if you notice a side effect after an injection, you must contact your practioner immediately.

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CONSENT FORM

I agree to receive Genius dermal filler injections.

The area to be treated is .....

I hereby authorise ..... to treat me using Genius dermal filler. 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 dermal filler. 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 for as per clinic price list.

I have been made award of the risk and I accept these terms and conditions as part of my treatment. My practioner 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 practioner in any means of compensation.

- The objectives and methods of the injection/treatment procedure have been clearly explained to me by the practioner
- I have received, read and understood the information supplied by the practioner prior to the injection/treatment
- I have had the opportunity to ask any necessary questions
- I understand the pre and post injection 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 and the rare cases of medical device vigilance
- I freely and voluntarily consent to receiving injections/treatment

Client Name .....
Client Signature .....
Date.....

Practioner Name.....
Practioner Signature .....
Date .....

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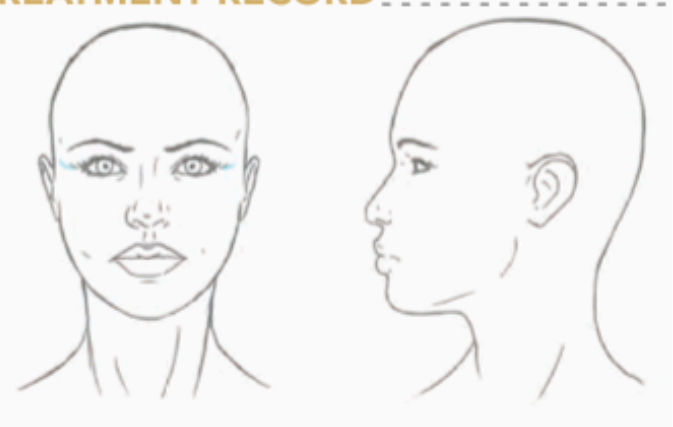
TREATMENT RECORD



PRODUCT STICKER

Date .....

Notes .....

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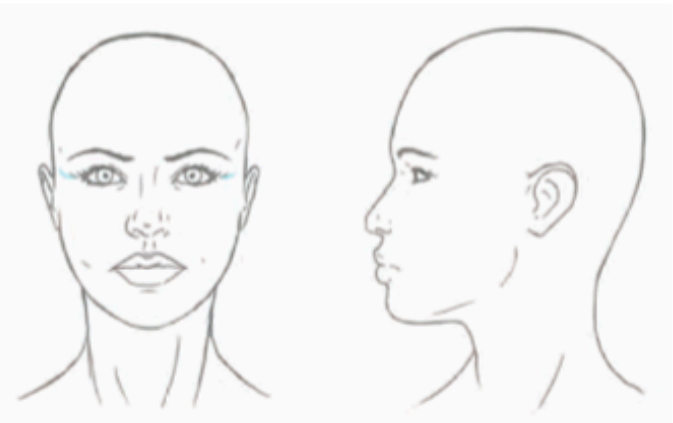
I confirm that I have been provided aftercare following my treatment.

PRINT _____SIGN _____ DATE_____



PRODUCT STICKER

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GENIUS+

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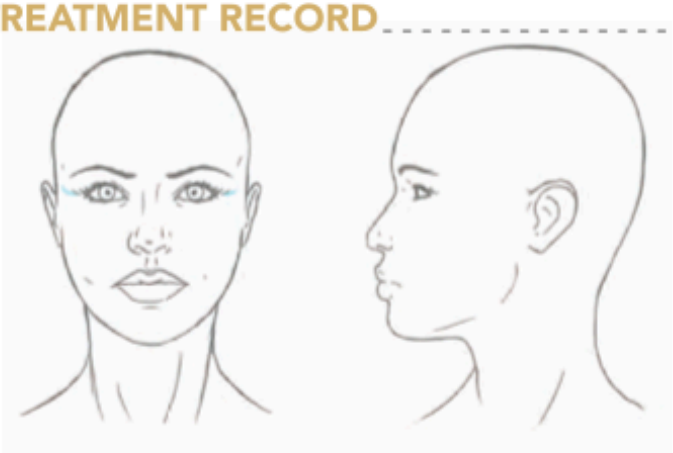

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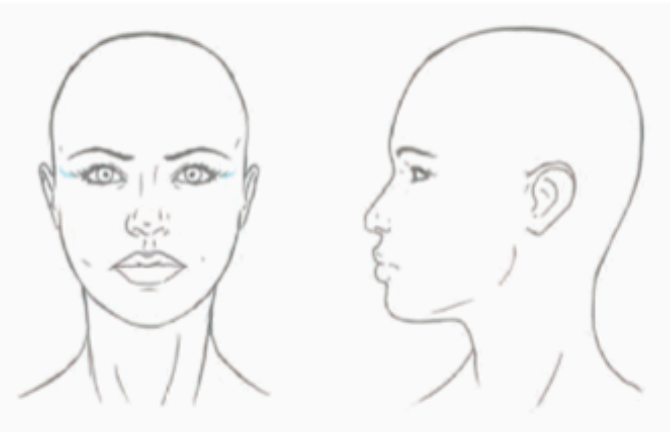

PRODUCT STICKER

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Notes .....

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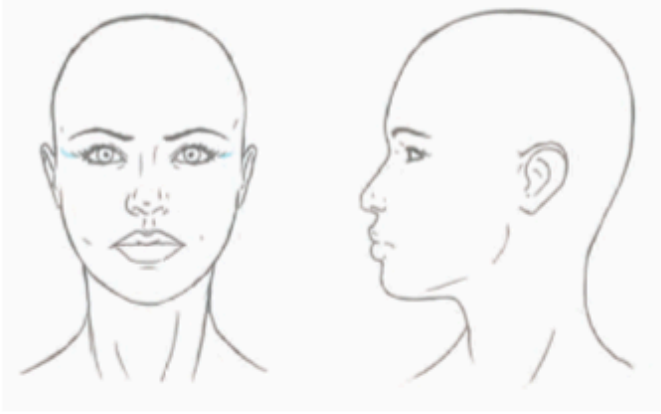
GENIUS+

TREATMENT RECORD



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Date .....

Notes .....

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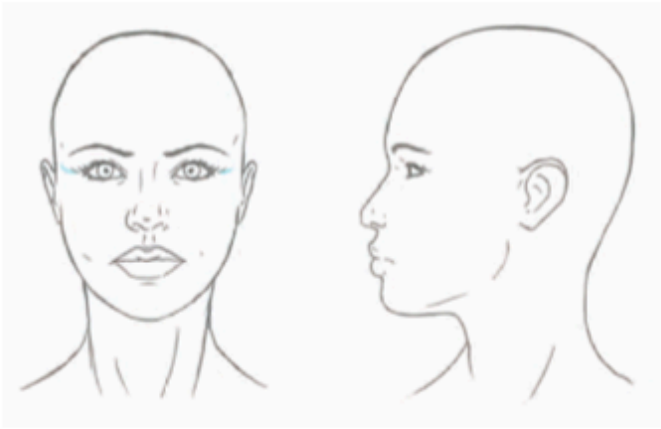

PRODUCT STICKER

Date .....

Notes .....

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GENIUS+