CONSENT & MEDICAL HISTORY FORM: **CONFIDENTIAL**

Your health is important to us. Please fill this out as accurately and completely as possible. Please take care to print legibly.
Please note your preferred method of contact by checking the box for email, mobile phone, or home phone.

PERSONAL INFORMATION:

FIRST:	MIDDLE:	LAST:	DATE:
ADDRESS:		EMAIL: ***PREFERRED***	
CITY, STATE, ZIP:		MOBILE PHONE: ***PREFERRED***	
BIRTH DATE:	GENDER: ***M*** ***F***	HOME PHONE: ***PREFERRED***	

TREATMENT CHECK-IN:

Are you currently under the care of a Health Care Provider? (If yes, please explain):

What was your most recent cosmetic treatment? (If this is your first cosmetic treatment, please state so.)

Person/Company who provided the treatment(s)?	Date of Last Treatment:

Have you ever fainted during or immediately following an aesthetic procedure?	***Yes***	***No***	Have you ever had a cosmetic procedure you did not like the outcome of?	***Yes***	***No***
Have you ever had a Rhinoplasty? If yes, how many? _____	***Yes***	***No***	Are you allergic to Eggs?	***Yes***	***No***
If so, did you experience any pain?	***Yes***	***No***	Are you allergic to Milk Protein?	***Yes***	***No***
			Are you allergic to Lidocaine®?	***Yes***	***No***

Do you have any other allergies or can you think of something you've had an adverse reaction to?

I do not have any known allergies ***I have an allergy or adverse reaction to (Please list)***

CURRENT MEDICATIONS:

List any medications that you are now taking below. Please include any & all non-prescription (over-the-counter) medications, vitamins, & supplements.

NAME (Medication/Vitamin/Supplement)	**DOSE (Please Include Strength/Per Day)**	**LENGTH (How long have you been taking this?)**
1.		
2.		
3.		
4.		

REPRODUCTIVE HISTORY: (Men, please skip to the next section):

Are you currently pregnant?	***Yes***	***No***	Have you been pregnant within the last year?	***Yes***	***No***	Are you currently breastfeeding?	***Yes***	***No***

SKIN HISTORY: Do you have or have you ever had:

	Please mark one		If yes, please explain (Provide frequency & most recent occurrence):
Keloid Scars	***Yes***	***No***	
Hives	***Yes***	***No***	
Skin Cancer	***Yes***	***No***	
Waxing	***Yes***	***No***	

SKIN HISTORY (Continued)

	Please mark one		If yes, please explain (Provide frequency & most recent occurrence):
Electrolysis	*Yes*	*No*	
Cold Sores	*Yes*	*No*	
Hypersensitivity to Skin Products	*Yes*	*No*	
Skin Infections	*Yes*	*No*	
Tanning Within the Last 6 Weeks	*Yes*	*No*	
Use of Acne Products or Drugs	*Yes*	*No*	
Laser Skin Resurfacing	*Yes*	*No*	
Chemical Peels	*Yes*	*No*	
Photo-sensitizing Substances	*Yes*	*No*	

Antibiotics, Diuretics, & Blood Pressure Medicine are all examples of photosensitizing substances.

Additional Information you would like to share related to your health (if any):

AGREED & SIGNED

I attest the above information to be true, knowing my practitioner(s) rely on this information to provide the most safe and effective treatment. **Print Name:**

PATIENT SIGNATURE:	DATE:

INFORMED CONSENT FOR BOTULINUM TOXIN & DERMAL FILLER INJECTIONS

BETWEEN THE Patient (YOU) & Beauty Lab Aesthetics, LLC

My signature and initials after each statement below constitutes my acknowledgement that:

1.	I, _____, consent to and authorize Beauty Lab Aesthetics _____ on (date) _____ the use of Botulinum Toxin (as an elective procedure) to improve general aesthetic appearance.	Initial:
2.	I am fully aware of the risks of complications or injuries that can occur from the treatment through the use of Botulinum Toxin, both from known and unknown causes, and I freely assume those risks. **Known complications could include:** **1. Redness, swelling, itching and discomfort can appear at the injection site.** **2. Repeated treatment(s) may lead to permanent loss of muscles for more than one week in the treated area(s).** **3. Some patients may develop Nodules or induration at the injection site antibodies to botulinum toxin (including but not limited to Discoloration of the injection site, poor effect BOTOX®).** **4. Allergic reactions, Bruising, and numbness may occur.** **5. The effects of BOTOX® are apparent two (2) - five (5) days after Facial asymmetry treatment & can take up to two (2) weeks for the full effect. Temporary paralysis leading to droopy eyelid and double vision is rare but can occur.** **6. The effects of BOTOX * can last for up to there (3) - four (4} months** **7. Weakness or flu-like symptoms months are rare but can occur.** **8. Visual problems, dry eye and itchy eyes can occur.** **9. Poor and unwanted effects may occur as a result of injecting into a blood vessel, and this may/can cause a result in blindness, numbness, loss of sensation or permanent or temporary damage to the area and body and cause financial costs, extended care and scar formation.** **10. In extremely rare cases skin necrosis or death of skin" may occur or discoloration of the injection site.**	Initial:

3. I, _____, consent to and authorize the Beauty Lab Aesthetics, LLC, BOTOX®/Dernal Filler on _____ on (date) _____ the use of Dermal Fillers (as an elective procedure) to improve general aesthetic appearance.	Initial:
4. I understand that it may take multiple treats to achieve the desired look I would like and at any time Beauty Lab Aesthetics can refuse treatment and to inject when they feel like it is not safe or beneficial to the patient. I understand that swelling may occur, and this can cause an asymmetrical look until swelling goes down. All enhancements will be on or after my 2 week appointment follow up in which I will be charge at that time for any new products that are used.	Initial:
5. The nature and purpose of the above elective treatment(s) has been explained to me and my questions regarding the treatment have been answered to my satisfaction.	Initial:
6. I understand surgery or other treatment alternatives may be as effective or more effective in reducing the appearance of wrinkles.	Initial:
7. I have not received any cosmetic injections within the last two weeks.	Initial:
8. I certify that I do not have any of the known conditions that would be a contraindication to receiving the treatment. These conditions include hypertrophic scars, a history of any autoimmune disease, or immune therapy. I am not pregnant, I am not breast-feeding, I am not planning a LASIK® procedure in the next month, and I have no mown allergy to botulinum toxin (including but not limited to BOTOX) or latex gloves should they be used). I am not allergic to eggs or milk protein.	Initial:
9. I certify that I do not have any of the known conditions that would contraindicate treatment. These conditions include hypertrophic scars, a history of any autoimmune disease, Vascular disease YIV or AIDS, immune therapy, or psychiatric disease. I am not pregnant, I am not breast-feeding, arc have no known allergy to Hyaluronic acid, anesthetic agents (including but not limited to Lidocaine), or latex gloves (should they be used).	Initial:
10. No guarantee, warranty, or assurances have been made regarding the treatment results.	Initial:
11. I acknowledge that there are risk factors with any procedure as well as the one provided today. I have been fully educated and all risk factors have been explained fully in detail.	Initial:
12. I understand that the results are of temporary nature, and subsequent or future treatments will be needed to maintain improvement I agree to adhere to all safety precautions described here including: **1. Avoiding prolonged sun or UV exposure** **2. Avoiding steam baths for two weeks after injection** **3. Avoiding saunas for two weeks after injection** **4. Makeup should be avoided for at least 12 hours after injection**	Initial:
13. Beauty Lab Aesthetics has the right to defer or refuse treatment on any patient should it be either of their opinion's that any treatment, or further treatment is not warranted.	Initial:
14. This agreement is binding, non-transferable and may not be altered by anyone without the express written consent of Beauty Lab Aesthetics, Further, this agreement does not expire.	Initial:
15. I agree that all the questions on this list and discussed are truthful and without false information and as therefore if any information is not answered correctly and truthful and results in injury or harm. Beauty Lab Aesthetics is and will not be held responsible.	Initial:
16. I agree to pay Beauty Lab Aesthetics for the procedures during today's session.	Initial:

I certify that I have read this entire informed consent and that I understand and agree to the information stated on this form. I certify that I am a competent adult of at least 18 years of age. This informed consent is freely and voluntarily executed and shall be binding upon my spouse, relatives, legal representatives, heirs, administrators, successors, and assigns. I agree that any picture taken of my treatment site may be used for publication and teaching purposes, however, my name will not be disclosed (unless I've provided permission in writing) and all reasonable attempts to maintain confidentiality will be made.

AGREED & SIGNED

PRINT NAME:

PATIENT SIGNATURE:	DATE: