415 BUSINESS PARK LANE, ALLENTOWN, PA 18109 | 610-844-7229

BRIEF MEDICAL HISTORY

BD# _____

Name _____ Birthdate _____ Ht._____ Wt._____

Full Address _____

Phone _____ Email _____

Referred By _____ Primary Care Physician _____

Medication _____ **Allergies** _____

_____ _____

_____ _____

_____ _____

_____ _____

Please answer "No" or "Yes" to the following. Do you have:

- A disease that affects your muscles and nerves (such as amyotrophic lateral sclerosis [ALS or Lou Gehrig's disease], myasthenia gravis or Lambert-Eaton syndrome)? ☐ No ☐ Yes
- Allergies to any botulinum toxin product? ☐ No ☐ Yes
- Had any side effect from any botulinum toxin product in the past? ☐ No ☐ Yes
- A breathing problem, such as asthma or emphysema? ☐ No ☐ Yes
- Swallowing problems? ☐ No ☐ Yes
- Bleeding problems? ☐ No ☐ Yes
- Plans to have surgery? ☐ No ☐ Yes
- Had surgery on your face? ☐ No ☐ Yes
- Weakness of your forehead muscles, such as trouble raising your eyebrows? ☐ No ☐ Yes
- Drooping eyelids? ☐ No ☐ Yes
- Any other change in the way your face normally looks? ☐ No ☐ Yes
- Are pregnant or plan to become pregnant? ☐ No ☐ Yes
  It is not known if BOTOX and BOTOX Cosmetic can harm your unborn baby.
- Are you breast-feeding or plan to breast-feed? ☐ No ☐ Yes
  It is not known if BOTOX and BOTOX Cosmetic passes into breast milk.

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 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.

Client Signature _____ Date _____

MD Signature _____ Date _____

Meesha AESTHETICS

INFORMED CONSENT FOR LATISSE® TREATMENT

WHAT ARE THE INDICATIONS FOR LATISSE® TREATMENT?

Latisse® is the brand name for bimatoprost, a sister medication already FDA approved for the treatment of glaucoma known as Lumigan®. Latisse® is FDA approved for the treatment of hypotrichosis of the eyelashes by making them grow longer, thicker and darker. Hypotrichosis is a medical term for short or missing lashes. It is frequently seen in men and women as they approach middle age. Latisse® is believed to affect the growth (anagen) phase of the eyelash hair cycle by increasing the length of the growth phase and increasing the number of hairs along the eyelid margin. The onset of action is gradual with most users seeing a significant improvement in the length and number of lashes by 2 months. If Latisse® is discontinued the eyelashes and eyelids will return to their previous appearance over several weeks to months.

WHAT ARE THE RISKS and POSSIBLE SIDE EFFECTS OF USING LATISSE®?

1. The following side effects are the most frequently reported, but occur in less than 4% of users (i.e. 4 out of 100 users):
    a. Eye irritation and itching
    b. Conjunctival hyperemia or red eye (redness of the white, moist covering of the eyeball)
    c. Dry eye symptoms
    d. Eyelid redness
2. Although rare, Latisse® has the potential to permanently increase the brown pigmentation of the iris (colored part of the eyeball, inside the eye).
3. Latisse® may cause hyperpigmentation or darkening of the eyelid skin which may or may not be reversible upon discontinuation of the treatment.
4. Latisse® may lower intraocular pressure (IOP) or pressure inside the eye; however, the magnitude of this reduction is usually not a cause for concern.
    a. If you have a history of abnormal eye pressures or glaucoma you should only use Latisse® under the close supervision of your ophthalmologist.
    b. Inform anyone conducting an eye pressure examination that you are using Latisse®.
5. You should inform your ophthalmologist that you are using Latisse® if eye surgery is planned.
6. Do not use Latisse® if you are allergic or hypersensitive to bimatoprost (Lumigan®) or any other ingredient in this product.
7. Latisse® is intended for use on the skin at the base of the eyelashes of the UPPER eyelids only.
8. DO NOT APPLY to the lower eyelids as this will increase the chance of side effects such as hyperpigmentation or darkening of the eyelid skin.
9. You should discontinue use of Latisse® and call your physician immediately if you develop an eye infection, sudden decrease in vision, suffer eye trauma, or develop eye or eyelid reactions.

WHAT ARE THE CONTRAINDICATIONS OF USING LATISSE®?

You should NOT use Latisse® if: you are allergic or hypersensitive to bimatoprost (Lumigan®) or any other ingredient in this product; are about to undergo cataract or other eye procedures, have an intraocular inflammation (uveitis), have risk factors for macular edema, have an eye infection, or are being treated for glaucoma with eye drops, unless cleared by your treating ophthalmologist. LATISSE® is not approved for people under the age of 18. It is not recommended for pregnant or lactating women.

PATIENT'S ACCEPTANCE OF RISKS

I have read the above information and have discussed it with my physician. I understand that it is impossible for the physician to inform me of every possible complication that may occur. My physician has told me that results cannot be guaranteed. By signing below, I agree that my physician has answered all of my questions and I give informed consent to proceed with Latisse® treatment.

I have read and understand all information presented to me before signing this consent. I have had ample opportunity to ask any questions regarding skin resurfacing treatment, side effects and after care.

Client/Guardian Signature _____ Date _____

Staff Signature _____ Date _____

Meesha AESTHETICS

415 BUSINESS PARK LANE, ALLENTOWN, PA 18109 | 610-844-7229

INJECTION OF BOTULINUM A TOXIN

Botulinum A Toxin (Botox) is used in the cosmetic treatment fot glabellar frown lines (wrinkles between the eyebrows), forehead lines, and crow's feet (lines around the lower eyes.) Botulinum A Toxin (Botox) is approved by the Food and Drug Administration (FDA) for the treatment of eyelid spasm, muscle spasm causing crossed eyes, correcting one-sided facial muscle spasms, as well as the cosmetic treatment of glabellar frown lines. Although used for cosmetic treatment for forehead lines and crow's feet, Botulinum A Toxin (Botox) is not yet approved by the FDA for that purpose.

Injection of this material into the small muscles between the brows, in the forehead, and at the corners of the eyes causes those specific muscles to halt their function (be paralyzed), thereby improving the appearance of the wrinkles. This paralysis is temporary, and reinjection is necessary within three to ten months to maintain the result. Options for alternative treatment include injection of either collagen or free fat, or the surgical excision of the muscles, usually through a brow-lift incision. Complications are rare, but may include paralysis of a nearby muscle resulting in temporary loss of function (i.e. drooping eyelid.)

CONSENT

I, _____ understand that Michelle Balbi, RN, will inject Botulinum A Toxin (Botox) into the glabellar, forehead or crow's feet muscles to paralyze these muscles temporarily.

I understand the goal is to decrease the wrinkles in that area. I understand that complications are rare, but may include temporary paralysis of other nearby muscles, headache, local numbness, rash and bruising.

It has been explained to me that other temporary and more permanent treatments are available. I understand there is no guarantee of results of any treatment.

I understand that the FDA has approved Botulinum A Toxin (Botox) for problems concerning the eye and face, including treatment of glabellar frown lines, but not for other cosmetic uses.

I agree to have both pre and post operative photos taken for my record and for patient education purposes. My name will not be used on any such photographs.

I have read this entire information sheet and authorize Michelle Balbi, RN to inject Botulinum A Toxin (Botox) into the muscles determined appropriate to improve my wrinkles.

Nurse Injector _____

Signature _____ Date _____

Witness/Nurse Signature _____

Meesha AESTHETICS
415 BUSINESS PARK LANE, ALLENTOWN, PA 18109 | 484-788-9529

SKINMEDICA® PEELS CONSENT

❑ Illuminize Peel® ❑ Vitalize Peel® ❑ Rejuvenize Peel™

PURPOSE:
The SkinMedica® Peels range from very superficial to superficial, designed to improve the texture and appearance of your skin.

PATIENTS WHO SHOULD NOT BE TREATED:

- Patients with active cold sores or warts, skin with open wounds, sunburn, excessively sensitive skin, dermatitis or inflammatory rosacea in the area to be treated. Inform the technician if you have any history of herpes simplex.
- Patients with a history of allergies (especially allergies to salicylates like aspirin), rashes, or other skin reaction, or those who may be sensitive to any of the components in this treatment.
- Patients who have taken Accutane® within the past year.
- Patients who are pregnant or breastfeeding (lactating).
- Patients who have received chemotherapy or radiation therapy (Medical Clearance is required).
- Patients with vitiligo.
- Patients with a history of an autoimmune disease (such as rheumatoid arthritis, psoriasis, lupus, multiple sclerosis, etc.) or any condition that may weaken their immune system.
- Current skin cancer within one year or pre-malignant moles in the treatment area (Medical Clearance is required).
- Active condition in the treatment area such as sores, psoriasis, eczema or rash.

SKINMEDICA® PEEL TREATMENT NOTES:

- Patients must wait 4 weeks after Laser therapy.
- Patients must wait 4 weeks after cosmetic filler treatments.
- Patients must wait 2 weeks after Microdermabrasion treatments.
- Patients must wait 4 weeks after eMatrix™ treatments.

TWO WEEKS BEFORE your SkinMedica® Peel avoid these products and/or procedures:

- Electrolysis • Waxing • Depilatory Creams
- Patients who have Botox® injections should wait until the full effect of their treatment is seen before receiving a SkinMedica® Peel.

ONE WEEK BEFORE your SkinMedica® Peel avoid these products and/or procedures:

- Laser Hair Removal
- eMatrix™
- Skin Tightening
- FotoFacial®
- Microdermabrasion
- Glycolic Peels
- Injectable Treatments

THREE DAYS BEFORE your SkinMedica® Peel avoid these products and/or procedures:

- Retin-A®, Renova®, Differin®, Tazorac®
- Any products containing retinol, alpha-hydroxy acid (AHA) or beta-hydroxy acid (BHA), or benzoyl peroxide.
- Any exfoliating products that may be drying or irritating.

Note: The use of these products/treatments prior to your peel may increase skin sensitivity and cause a stronger reaction.

INFORMED CONSENT FOR JUVÉDERM®, JUVÉDERM® ULTRA XC, JUVÉDERM® ULTRA PLUS XC TREATMENT, RESTYLANE® AND PERLANE®

Indications

JUVÉDERM®, JUVÉDERM® Ultra XC and JUVÉDERM® Ultra Plus XC injectable gel are injected into areas of facial tissue where moderate to severe facial wrinkles and folds occur. It temporarily adds volume to the skin and subcutaneous tissues which may give the appearance of a smoother skin surface and may help smooth moderate to severe facial wrinkles and folds.

Correction is temporary; therefore, touch-up injections as well as repeat injections are usually needed to maintain optimal correction. Less material (about half the amount) is usually needed for repeat injections. Most patients need one or possibly two treatments to achieve optimal wrinkle smoothing. The results may last as long as nine months to one year.

Alternatives

Other treatments for dermal soft-tissue augmentation include, but are not limited to, products such as RADIESSE®. Restylane®, Hylaform, Cosmoderm™, and Perlane®. Aside from these treatments, additional options for the correction of lines and wrinkles do exist, including facial creams, BOTOX® Cosmetic (Botulinum Toxin Type A), chemical peels, laser skin surface treatments, and surgery. Other options not mentioned here may exist. All options should be discussed with your physician.

Side Effects and Complications

Most side effects are mild or moderate in nature, and their duration is short lasting (7 days or less). The most common side effects include, but are not limited to, temporary injection-site reactions such as: redness, pain/tenderness, firmness, swelling, lumps/bumps, bruising, itching, infection, and discoloration.

In the first 24 hours after injection, you should avoid strenuous exercise, extensive sun or heat exposure, and alcoholic beverages. Exposure to any of the above may cause temporary redness, swelling, and/or itching at the injection sites. If there is swelling, you may need to place an ice pack over the swollen area. You should ask your physician when makeup may be applied after your treatment.

Be sure to report any redness and/or visible swelling that lasts for more than a few days, or any other symptoms that cause you concern.

Contraindications

JUVÉDERM®, JUVÉDERM® Ultra XC and JUVÉDERM® Ultra Plus XC injectable gel should not be used if you have:

- Severe allergies marked by a history of anaphylaxis or history or presence of multiple severe allergies
- A history of allergies to Gram-positive bacterial proteins

The following are important treatment considerations for you to discuss with us and understand in order to help avoid unsatisfactory results and complications:

- **Please inform us prior to treatment:** If you are using substances that can prolong bleeding, such as aspirin, or ibuprofen, as with any injection, you may experience increased bruising or bleeding at the injection site.
- **Please inform us prior to treatment:** If you are on immunosuppressive or therapy used to decrease the body's immune response, as there may be an increased risk of infection.
- **Please inform us prior to treatment:** If you are pregnant or breast feeding.
- **Please inform us prior to treatment:** If you have history of excessive scarring (eg, hypertrophic scarring and keloid formations) and pigmentation disorders.

If laser treatment, chemical peeling, or other procedure based on active dermal response is considered after treatment with JUVÉDERM®, JUVÉDERM® Ultra XC and JUVÉDERM® Ultra Plus XC injectable gel, there is a possible risk of an inflammatory reaction at the treatment site.

The safety and effectiveness of JUVÉDERM®, JUVÉDERM® Ultra XC and JUVÉDERM® Ultra Plus XC injectable gel for the treatment of areas other than facial wrinkles and folds (such as lips) have not been established in controlled clinical studies. Use in patients under 18 years has not been established.

Patient's Acceptance of Risks

I have read the above information and have discussed it with my physician. I understand that it is impossible for the doctor to inform me of every possible complication that may occur. No guarantees about results have been made. By signing

below, I agree that my doctor has answered all of my questions and that I understand and accept the risks, and alternatives of JUVÉDERM®, JUVÉDERM® Ultra XC and JUVÉDERM® Ultra Plus XC.

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 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 have read and understand all information presented to me before signing this consent. I have had ample opportunity to ask any questions regarding skin resurfacing treatment, side effects and after care.

Client/Guardian Signature _____ Date _____

Staff Signature _____ Date _____

INFORMED CONSENT FOR RADIESSE® TREATMENT

I _____ understand that I will be injected with RADIESSE® dermal filler in the following areas: _____

RADIESSE® dermal filler is a resorbable implant product approved by the United States Food and Drug Administration for the correction of moderate to severe facial wrinkles and folds, such as nasolabial folds.

Risks and complications that may be associated. with RADIESSE® dermal filler and the implant procedure include, but are not limited to:

1. **Facial Bruising, Redness, Swelling, Itching and Pain:** I understand that there is a risk of bruising, redness, swelling, itching and pain associated with the procedure. These symptoms are usually mild and last less than a week, but can last longer. Patients who are using medications that can prolong bleeding, such as aspirin, warfarin, or certain vitamins and supplements, may experience increased bruising or bleeding at the injection site.
2. **Nodules, and Palpable Material:** I understand that there is a risk that small lumps may form under my skin due to the RADIESSE® filler material collecting in one area. I also understand that I may be able to feel the RADIESSE® filler material in the area where the material has been injected. Any foreign material injected into the body may create the possibility of swelling or other local reactions to a filler material.
3. **Migration:** I understand that the RADIESSE® dermal filler, as with any filler material, may move from the place where it was injected.
4. **Infection:** As with all transcutaneous procedures, I understand that injection of any filler material carries the risk of infection.
5. **Allergic Reactions:** I understand that RADIESSE® dermal filler should not be used in patients with severe allergies, a history of anaphylaxis, or history or presence of multiple severe allergies or hypersensitivity to any of the ingredients in RADIESSE® filler.
6. **Keloids/Scarring:** I understand that the safety of RADIESSE® dermal filler in patients with known susceptibility to keloid formation or hypertrophic scarring has not been studied.
7. **Accidental Injection into a Blood Vessel:** I understand that RADIESSE® dermal filler can be accidentally injected into a blood vessel, which may block the blood vessel and cause local tissue damage, or potentially even a heart attack or stroke.
8. **Radio-opacity:** I understand that RADIESSE® dermal filler is radio-opaque and is visible on CT Scans and may be visible in x-rays.
9. **Duration of Effect:** I understand that the outcome of treatment with RADIESSE® dermal filler will vary among patients. In some instances, additional treatments may be necessary to achieve the desired outcome.

No studies of interactions of RADIESSE® dermal filler with drugs or other substances or implants have been conducted .

This above list is not meant to be inclusive of all possible risks associated with RADIESSE® dermal filler or dermal fillers in general, as there are both known and unknown side effects and complications associated with any medication or dermal filler injection procedure. I understand that medical attention may be required to resolve complications associated with my injection.

I understand that I should minimize exposure of the treated area to the sun or heat for approximately 24 hours after treatment or until any initial swelling or redness goes away.

The safety of RADIESSE® dermal filler for use during pregnancy or in breastfeeding women has not been established.

I have discussed the potential risks and benefits of RADIESSE® dermal filler with my doctor. I understand that there is no guarantee of any particular results of any treatment.

Patient's Acceptance of Risks

I have read the above information and have discussed it with my physician. I understand that it is impossible for the doctor to inform me of every possible complication that may occur. No guarantees about results have been made. By signing below, I agree that my doctor has answered all of my questions and that I understand and accept the risks, and alternatives of RADIESSE®.

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 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 have read and understand all information presented to me before signing this consent. I have had ample opportunity to ask any questions regarding skin resurfacing treatment, side effects and after care.

Client/Guardian Signature _____ Date _____

Staff Signature _____ Date _____