

Consultation

Aesthetics Medical History & Consultation

Date.....

Full Name

Date of Birth

Email

Contact Number

Address

Emergency Contact Name:

Emergency Contact Number:

Please indicate if you would like updates regarding reminders, offers and products in the future via email (you can unsubscribe at any time).

Y N

Please indicate if you would like updates regarding reminders, offers and products in the future via SMS (you can OPT-OUT at any time).

Y N

Medical History

Areas interested in treating:

Are you currently receiving any treatment from a doctor or specialist?

Y N

If YES, please give details:

Are you taking any medication, supplements, or herbal remedies?

Y N

If YES, please give details:



Are you currently pregnant?

Y N

If YES, how far along?

Do you have a history of any of the following conditions?

- | | |
|-------------------------------------------------------------|--------------------------------------------------------------|
| <input type="radio"/> Heart problems | <input type="radio"/> Cuts/abrasions |
| <input type="radio"/> Jaundice/Hepatitis | <input type="radio"/> Eczema |
| <input type="radio"/> Epilepsy/Blackouts | <input type="radio"/> Psoriasis |
| <input type="radio"/> Melasma (pigment changes in the face) | <input type="radio"/> Acne |
| <input type="radio"/> Diabetes | <input type="radio"/> Skin disorders/diseases |
| <input type="radio"/> Keloids | <input type="radio"/> Albinism/Vitiligo |
| <input type="radio"/> Blood disorders | <input type="radio"/> Port-wine stains/Strawberry birthmarks |
| <input type="radio"/> Moles (Melanocytic, Naeu/Melanoma) | <input type="radio"/> Pigment birthmarks |
| <input type="radio"/> Recent scar tissue (within 6 months) | <input type="radio"/> Cold sores |
| <input type="radio"/> Sunburn | <input type="radio"/> Psychiatric illness/Depression |
| <input type="radio"/> Bruises | <input type="radio"/> HIV |
| <input type="radio"/> Unidentified oedema | <input type="radio"/> Stomach ulcers |
| <input type="radio"/> Unidentified lumps | <input type="radio"/> Glaucoma/cataracts |
| <input type="radio"/> Heart disease | <input type="radio"/> Venereal disease |
| <input type="radio"/> Thyroid problems | <input type="radio"/> Bell's palsy |
| <input type="radio"/> Arthritis | <input type="radio"/> Phlebitis |
| <input type="radio"/> Asthma/bronchitis | <input type="radio"/> Hypoglycaemia |
| <input type="radio"/> Convulsions | |

Do you have any disease, disorder, or problems not listed above?

Y N

If YES, please describe:

Are you currently pregnant or breastfeeding?

Y N

Are you planning to get pregnant or breastfeed in the near future?

Y N

If Yes, please specify.

Do you smoke?

Y N

If Yes, how many per day?

If No but you smoked in the past, when did you give up?



Do you drink alcohol?

Y N

If Yes, how many units per week?

Do you exercise regularly?

Y N

If Yes, what type of exercise do you do?

Do you suffer from any allergies?

Y N

If Yes, please give details?

Have you ever had an allergic reaction to any beauty treatment including injectables? If Yes, please give details?

Y N

Have you had any cosmetic treatment?

Y N

If Yes, please give details?

Do you suffer from Myasthenia Gravis or Eaton Lambert syndrome?

Y N

Is there any other aspects of your health that you think we should know about?

I have answered these questions to the best of my understanding (signature):

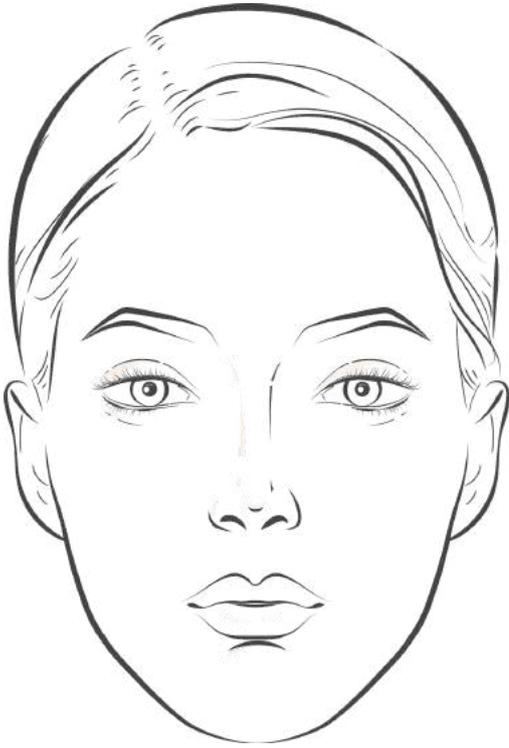
Practitioners signature:



First Name

Last Name

Date



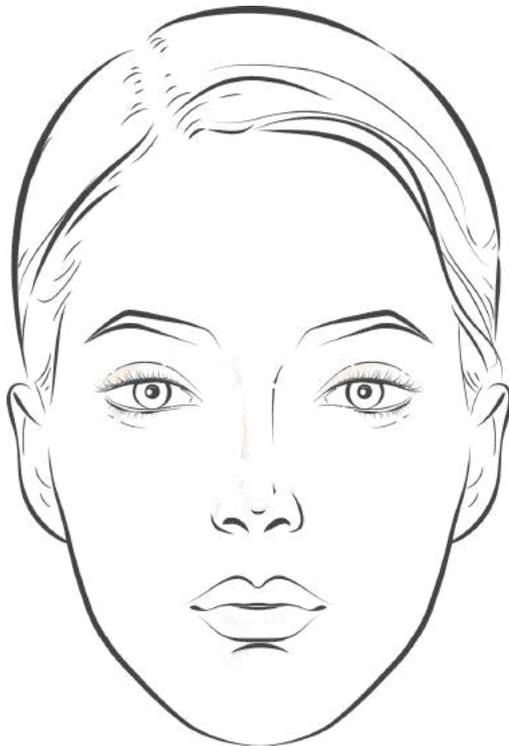
Area Treated: _____

Product Type: _____

Batch Nr.: _____

Notes: _____

Date



Area Treated: _____

Product Type: _____

Batch Nr.: _____

Notes: _____



Botulinum Toxin Injection Consent

You have the right to be informed about the proposed treatment so that you may make the decision whether or not to undergo the procedure after knowing the risks and complications involved. This disclosure is not meant to create anxiety but is simply an effort to better inform you so that you may give or withhold your consent. Botulinum toxin injections may include but are not limited to, the following risks and complications: (Please enter your initials if you agree with each statement)

- _____ 1. Allergic reactions, including rash, itching, local swelling, or more severe reactions.
- _____ 2. Botulinum toxin contains albumin from human blood, to which certain individuals are allergic. If you have had adverse reactions to certain immunisations or are allergic to eggs, you should not use botulinum toxin.
- _____ 3. The effects of botulinum toxin are potentiated (increased) when patients are taking certain antibiotics (aminoglycoside derivatives) and other drugs that interfere with neuromuscular transmission. Be sure to advise your practitioner of all medications you are taking or have recently taken.
- _____ 4. Because botulinum toxin contains human albumin, there is a remote chance of transmission of serious viral diseases. This complication has never been identified, but it is possible.
- _____ 5. Bruising may be possible, especially if botulinum toxin is used around the eye area. Typically, these discoloured areas disappear with time.
- _____ 6. If used around the eye, botulinum toxin may cause difficulty in closing eyelids tightly. The result may be corneal exposure with resultant drying, potential ulceration, and visual complications. The affected eyelid may droop. Protective patching and/or medication may be required until this complication has passed.
- _____ 7. The safety of botulinum toxin in pregnant women or nursing mothers has not been established.

_____ I have fully and truthfully informed my practitioner of my past medical and social history, including drug and alcohol use, recognising that withholding information may jeopardise the planned outcome of this treatment. I agree to cooperate fully with my practitioners' recommendations while under treatment, realising that any lack of cooperation can result in a less-than-optimal result. If any unforeseen condition should arise during this procedure calling for additional or different procedures from those planned, I authorise my practitioner to use professional judgment to provide the appropriate care to complete the procedure. I understand this is an elective procedure and have not been given any warranty or guarantee as to the result of the proposed procedure.

_____ I certify I have had an opportunity to read the above paragraphs and I fully understand the terms used. I understand the reasons for the proposed treatment and its potential benefits to me it has been explained to me what alternatives there are, if any, to this treatment. All my questions have been answered to my satisfaction and I am willing to undergo this elective treatment. I also state that I read, speak and understand English.

Client Name

Date

Client Signature

Practitioners' signature.



Dermal Filler Injection Consent

You have the right to be informed about the proposed treatment so that you may make the decision whether or not to undergo the procedure after knowing the risks and complications involved. This disclosure is not meant to create anxiety but is simply an effort to better inform you so that you may give or withhold your consent. Botulinum toxin injections may include but are not limited to, the following risks and complications: (Please enter your initials if you agree with each statement)

This is an informed consent document that has been prepared to help inform you concerning Dermal Filler injections and the risks involved. It is important that you read this information carefully and completely. Please initial each contraindication, indicating that you have read and understood it, and sign the consent at the bottom prior to your treatment.

Dermal fillers are used to correct volume loss, shape, contour, and reduce the appearance of fine and/or deep lines. They consist of Hyaluronic acid which is a naturally-occurring gel produced in the body, which is injected into the treatable area. Fillers consist of local anesthetic gel which minimises discomfort. The results can often be seen immediately after injection and can last anything between 8-18 months.

Every procedure involves a certain amount of risk, and it is important that you understand the risks involved. An individual's choice to undergo a procedure is based on the comparison of the risk to potential benefit. Although the majority of patients do not experience these complications, you should discuss each of them with your practitioner to make sure you understand the risks, potential complications, and consequences of dermal filler injections:

- Bleeding
- Bruising/Swelling
- Infection
- Lumpiness
- Discolouration

CAUTIONS & CONTRAINDICATIONS (To be checked with the patient prior to treatment)

- Pregnancy/Breastfeeding
- Infected skin area e.g. cold sores/cellulitis etc.
- Anticoagulant use (e.g. Warfarin/Aspirin)
- Known hypersensitivity to hyaluronic acid or any of its excipients e.g. Lidocaine

Photographs will be taken for documentation and will be stored electronically for reference purposes only and will not be passed on to any third party. Staff authorised by Cole Aesthetics Clinic are trained in Data Protection and Clinical Governance and may process the files for storage only.

Client Name

Date

Client Signature

Practitioners' signature.



Pre-Injection ADVICE

- DO NOT consume blood-thinning substances for 5-days prior to your treatment. The most common culprits are things like Aspirin, St. John's wort, Fish Oil, Vitamin E, and/or tons of alcoholic beverages. (These are all anti-coagulators, and will increase the likelihood of bruising and bleeding at the injection site.)
- DO NOT schedule your treatment within 3-weeks of any big-event. (Anytime the skin is being broken, there is a chance for bruising or swelling. Please make sure to give your body plenty of healing time before an event in case this occurs.)
- DO NOT: If you have had recent dental work, it is not safe to move forward with lip-injections. Please wait for at least 2 weeks between lip injections and dental work to make sure that all wounds have had time to heal and there is no risk of spreading bacteria.
- DO NOT: If you are pregnant or breast-feeding, it is not safe for you to undergo any cosmetic injections.
- DO tell us if you have previously suffered from facial cold sores. (We can prescribe a medication to minimize the chance of a break-out.)
- DO feel free to bring a picture of your desired outcome. Our definition of "plumped" or "smoothed" or "contoured" could vary drastically from yours. We want to make sure we are on the same page as you.
- DO you have micro-bladed eyebrows? If so, please call your brow-provider to see what they recommend for Botox with your eyebrow treatment.
- DO you know that you bruise easily? Please tell at the time of scheduling and we can make suggestions for products to take beforehand to help with this.

Next Appointment	Date	Time
	Date	Time
	Date	Time



Post-Injection ADVICE

- DO use cold compresses to reduce swelling or bruising but DO NOT apply a lot of pressure when using your compress against your skin
- DO NOT lie down for at least 4-hours after a b.toxin treatment.
- DO NOT engage in aerobic activities for 24-hours after an injection treatment. Although extremely rare, you do not want any product to migrate from its injection site.
- DO NOT sleep flat on your face (if you can help it) for 3-4 x days after your treatment.
- DO NOT wear glasses or hats that may press against a treatment site for 6-hours afterward.
- DO remember that your final results are not necessarily visible immediately. It can take 14-days for b.toxin to fully kick in, and sometimes even longer for dermal-filler to fully integrate.
- DO try to avoid touching the treated area for the first six hours following treatment.
- DO avoid intense heat (sun lamp or sunbathing).
- DO make sure to stay hydrated and drink lots of water, this will help everything work to its full capacity.
- DO feel free to make a lot of exaggerated facial expressions immediately after your b.toxin treatment to make sure the product has integrated into your muscle.
- DO add an extra-pillow under your head before you go to bed (after dermal-filler treatments). The extra elevation can help prevent swelling.
- DO remember to ask about follow-up appointments!
- DO call us with any questions or concerns you may have after your treatment, it's what we are here for!

Next Appointment	Date	Time
	Date	Time
	Date	Time



COVID-19 CONSENT FORM

- I knowingly and willingly consent to have an aesthetic treatment by BUSINESS NAME during the COVID-19 pandemic.
- I acknowledge that BUSINESS NAME has put in place preventative measures to reduce the spread of the Coronavirus/COVID-19.
- I further acknowledge that BUSINESS NAME can not guarantee that I will not become infected with the Coronavirus/Covid-19.
- I understand that the risk of becoming exposed to and/or infected by the Coronavirus / COVID-19 may result from the actions, omissions, or negligence of myself and others, including, but not limited to, clinic staff, and other clients visiting the clinic and their families (if applicable) I understand the risk involved in having elective treatment even though I have been identified by the NHS/National health organization as being in a vulnerable health group and advised to shield.
- I voluntarily seek services provided by BUSINESS NAME and acknowledge that I am increasing my risk of exposure to the Coronavirus/COVID-19.
- I acknowledge that I must comply with all set procedures to reduce the spread while attending my appointment.
- I confirm that I do not currently have any of the following symptoms of COVID- 19 listed below:
- Temperature above 38°C/100.4F
 - Shortness of breath
 - Loss of sense of taste or smell
 - Persistent cough
- I confirm that, to the best of my knowledge, I have not been around anyone with these symptoms in the past 14 days.
- I confirm I am not self-isolating due to a family member having COVID-19 symptoms. I confirm I have not been asked to self-isolate due to travel outside of the YOUR COUNTRY / STATE in the past 14 days

First Name

Last Name

Signature

Date & Place

