OCEAN MED SPA

MEDICAL HISTORY FORM

Last Name: _____ First Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Telephone: Home: _____ Work: _____ Cell: _____

Date of Birth: _____ Sex: Female _____ Male _____

Family Doctor: _____ Phone: _____

Pharmacy: _____ Phone: _____

Emergency Contact: _____ Phone: _____

Which body area/areas or condition would you like treated? _____

_____

_____

Please answer all of the following questions	**YES**	**NO**
1. Do you have **ANY** current or chronic medical illnesses? Disclose any history of heat urticaria, diabetes, autoimmune disorders or any immunosuppression, blood disorders, cancer, bacterial or viral infections, medical conditions that significantly compromise the healing response, skin photosensitivity disorders, or <u>any</u> other condition or illness. Please List: _____	O	O
2. Do you have **ANY** current or chronic skin conditions? Also disclose any history of vitiligo, eczema, melasma, psoriasis, allergic dermatitis, any diseases affecting collagen including Ehlers-Danlos syndrome, scleroderma, skin cancer, or <u>any</u> other skin condition. Please List: _____	O	O
3. Are you currently under a doctor's care? If so, for what reason? _____	O	O
4. Do you take/use **ANY** medications (prescriptions and nonprescriptions), vitamins, herbal or natural supplements, on a regular or daily basis? Please List: _____	O	O
5. Are there any topical products (both medical and non-medical) that you use on your skin on a regular or daily basis? Please List: _____	O	O
6. Do you take/use ANY systemic/oral steroids (e.g., prednisone, dexamethasone)?	O	O
7. Do you have **ANY** allergies to medications, foods, latex or other substances? Please List: _____	O	O
8. (For women) are you or could you be pregnant?	O	O
9. (For women) are menstrual periods irregular, or have you ever been diagnosed with Polycystic Ovarian Disorder?	O	O
10. Do you have a history of herpes I or II in the area to be treated?	O	O
11. Do you have a history of keloid scarring or hypertrophic scar formation?	O	O
12. Do you have a history of light induced seizures?	O	O
13. Do you have any open sores or lesions?	O	O
14. Do you have any history of radiation therapy in the area to be treated?	O	O

MEDICAL HISTORY, CONTINUED **YES** **NO**

15. In the last six (6) months, have you used any of the following: anticoagulants or blood-thinning medications; photosensitizing medications; or anti-inflammatory or blood thinning medications? O O
Please List product name and date last used: _____
_____

16. In the last three (3) months, have you used any of the following products: glycolic acid or other alphahydroxy or betahydroxy acid products; exfoliating or resurfacing products or treatments? O O
Please List product name and date last used: _____
_____

17. Do you have or have you ever had any permanent make-up, tattoos, implants, or fillers,including, but not limited to, collagen, autologous fat, Restylane®, etc.? O O
If yes, please list locations on or in the body and dates: _____
_____

18. Do you have or have you ever had any Botulinums, such as Botox® or Dysport®? O O
If yes, please list locations on or in the body and dates: _____
_____

19. Have you taken Accutane® (or products containing isotretinoin) in the last 12 months? O O
20. Have you taken Tretinoin (like Retin-A, Renova) in the last 6 months? O O
21. Have you had any unprotected sun exposure, used tanning creams (including sunless tanning lotions) or tanning beds or lamps in the last 4-6 weeks? O O
22. Do you have a pacemaker? O O

Please include your email address to receive appointment confirmations, and monthly information on special pricing and/or special events:

_____@_____

How did you hear about us? _____

Signature: _____ Date: _____

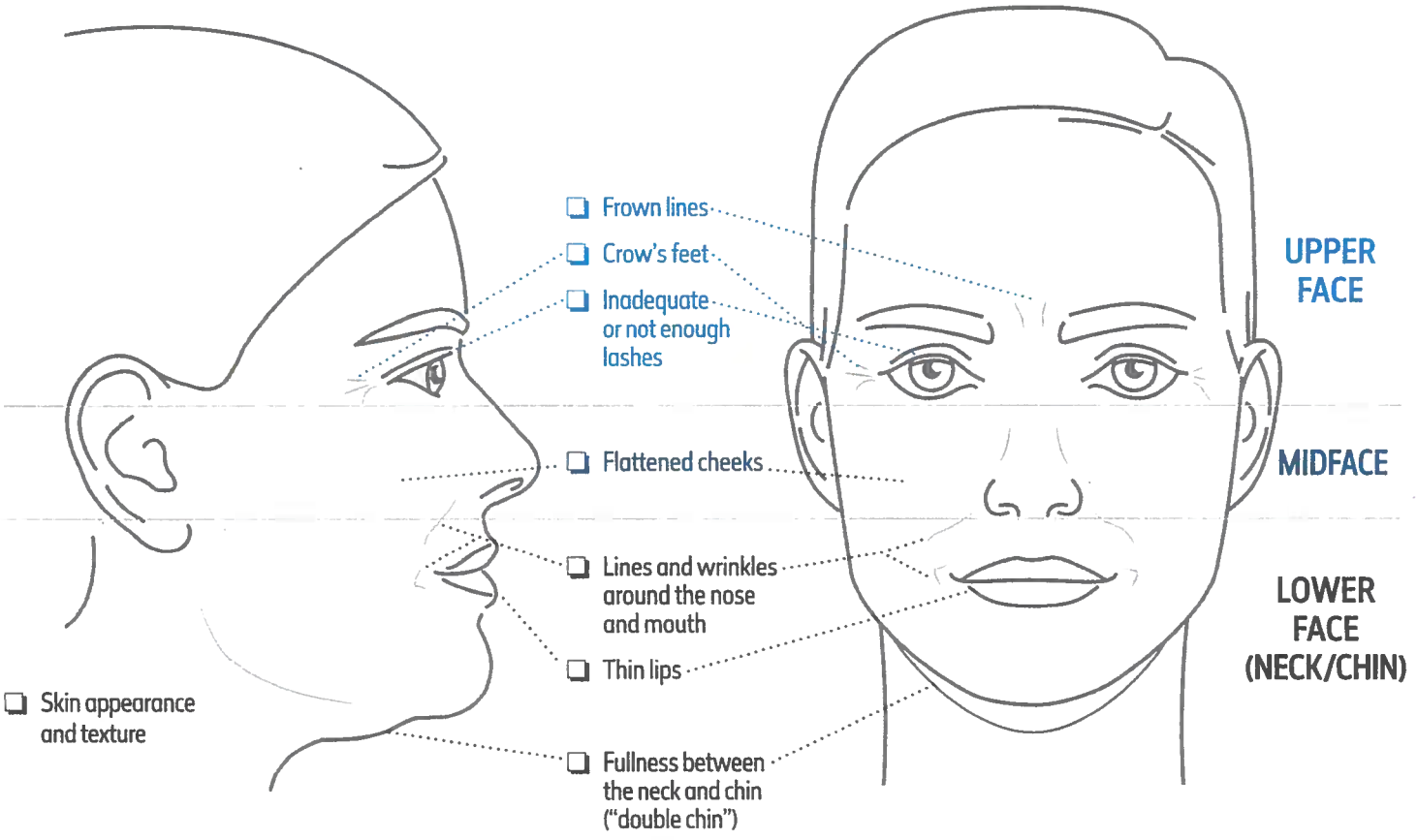
SELF-ASSESSMENT

NAME: _____ DATE OF BIRTH: _____ DATE: _____

What brings you in today? _____

Select which areas of the face concern you on the diagram below.

By sharing how you see yourself, we can best evaluate your aesthetic goals and select an appropriate treatment for you.



Please complete and return this form to the front office before your consultation.

INFORMED CONSENT FOR PDO THREAD LIFT PROCEDURE

The PDO (polydiaxonone)Threat Lift and Smoothing procedure uses absorbable surgical sutures placed into the subdermal layer of the skin to initiate collagen production. The procedure can result in increased firmness and elasticity of the skin in the treated area. The PDO Lift procedure is effective in most cases, however there is no guarantee a specific patient will benefit from the procedure. The nature of cosmetic procedure may require a patient to return for numerous visits in order to achieve the desired results or to determine whether the treatment may not be completely effective at treating the particular condition.

Alternative Treatments: Alternative forms form of non-surgical and surgical treatment consist of surgical facelift, Nd:YAG laser, full-face C02 laser, dermal fillers, local muscle relaxer (Botox, Dysport, Xeomin), chemical peels or inaction. Every procedure involves a certain amount of risk. An individual's choice to undergo a procedure is based on the comparison of the risk to the potential benefit. Although most patients do not experience adverse complications, you should discuss your concerns and potential risks with your practitioner in order to make an informed decision.

Possible Risks and Side Effects Associated with PDO Threat Lift Procedure:

Discomfort: Some discomfort may be experienced during treatment.
Scarring: May cause scarring; sutures are inserted using a small needle, which must heal. A scar a scar at entry point may occur.
Bruising, Swelling, Infection: With any minimally invasive procedure, bruising of the treat area may occur along with the potential for swelling and is likely. Infection is rare, but with any injection or incision into the skin, the possibility exists.
Bleeding: You may experience some bleeding during the procedure. Hematoma or a small blood clot may occur and may require treatment by drainage. There is a higher risk of bleeding if you have taken any anti-inflammatory medications (Advil, Motrin, Aspirin, Ibuprofen) within the 10 days preceding the procedure.
Damage to Deeper Structures: Deeper structures such as nerves, blood vessels and muscles may be damaged during the procedure. The potential for this to occur varies according to the location on the body the procedure is being performed. Injury to deeper structures may be temporary or permanent.
Allergic Reaction: Allergies to tape, suture material or topical preparations have been reported. allergic reactions may require additional treatment.
Anesthesia: Local topical anesthesia may be used and can involve risk of allergic reaction.
There is a possibility of the treatment area becoming lighter or darker than the surrounding skin. This is usually temporary, but on rare occasions, may be permanent. Appropriate sun protection is important.
Partial Laxity Correction: PDO Lift may not correct all your facial laxity or sagging.
Delay Healing: Complications may ensure as a result of smoking, using a straw, or similar motions. Smoking and similar actions are STRONGLY discouraged. Slight asymmetry, redness, visible sutures, suture breakthrough may require additional treatment or the removal of the sutures.
Contraindications: Any known allergy or foreign body sensitivities to synthetic biomaterials.

Additional Procedures May Be Necessary:

In some situations, it may not be possible to achieve optimal results with a single PDO Lift procedure and other procedures may be necessary. Although peak results are expected, there cannot be any guarantee or warranty expressed or implied on the results that may be obtained.

The cost of the procedure may involve several charges for serviced provided. The total may include fees charged by Ocean Medspa LLC, the cost of supplies, or laboratory tests if necessary. Additional costs may occur should complication develop from the procedure.

I understand that no warranty or guarantee of specific result has been made to me. I realize that, as in all medical treatment, complications or delay in recovery may occur which could lead to the need for additional treatment, and could result in a delay to one's normal daily activities and thus economic loss.

I understand my practitioner may discover other conditions which require additional or different procedures than planned treatment. I authorize my practitioner and his or her associates, technical assistants and other health care providers to perform such other procedures which are advisable in their professional judgment.

I understand my cheeks/jowls may not achieve the desired improvement anticipated.
I understand sutures may extrude, may have to be trimmed or may have to be removed in the future.
I understand the results may relax over time and additional procedures may be required.
I consent to the taking of photos before, during or after the procedure to document my progress.

The nature of the elective procedure, its risks and potential complications have been fully explained to me along with available alternative treatments and their benefits and risks has been discussed. I understand I have the right to refuse treatment. I have been instructed to and agree to abide by all safety precautions and post treatment instructions and have been given a written copy. I understand no refunds will be given for received treatment and no guarantee(s) have been given regarding the results. I release the facility, medical staff, and other technicians from liability associated with this procedure. This consent is voluntarily executed and shall be binding on my spouse, relative, legal representatives, heirs, administrators, successors and assignees. I also certify that if I have any changes in my medical history I will notify the Anew Medspa immediately. I also state that I read and write in English. If you have any questions or concerns, please call our office at 772-219-4552

_____ Date:_____
Patient Signature

Witness:_____