**Anti-wrinkle treatment questionnaire and consent form**

|  |  |  |
| --- | --- | --- |
| Name: | Phone: | |
| Address | Email: | |
| Date of birth: | |
| **Medical history** | **Yes / No** | **Details** |
| Are you pregnant or breastfeeding? |  |  |
| Do you have a history of severe allergy / anaphylaxis?  *If yes, give details.* |  |  |
| Are you currently receiving any medical treatment?  *If yes, give details.* |  |  |
| Have you previously received any aesthetic treatments, such as laser peels, dermabrasion etc.?  *If yes, give details.* |  |  |
| Have you had any treatment with dermal fillers, absorbable dermal fillers, semi-permanent dermal fillers or botulinum toxin?  *If yes, what areas were treated and when.* |  |  |
| Have you ever suffered from auto-immune disease or disease affecting the immune system?  *If yes, give details.* |  |  |
| Do you have any skin infection or inflammatory problems, such as herpes, acne etc.?  *If yes, give details.* |  |  |

|  |  |  |
| --- | --- | --- |
| **Medical history** | **Yes / No** | **Details** |
| Are you currently taking any steroids, aspirin or anticoagulant, such as warfarin?  *If yes, give details.* |  |  |
| Do you suffer from acute rheumatic fever or recurrent sore throat?  *If yes, give details.* |  |  |
| Do you suffer from any allergies, in particular, allergies to hyaluronic acid, amide-type local anaesthetics or lidocaine?  *If yes, give details.* |  |  |
| Do you suffer from untreated epilepsy?  *If yes, give details.* |  |  |
| Do you tend to develop hypertrophic scarring?  *If yes, give details.* |  |  |
| Do you suffer from porphyria?  *If yes, give details.* |  |  |
| Do you suffer from cardiac conduction disorders?  *If yes, give details.* |  |  |

If you answer ‘yes’ to any of the questions, your practitioner may ask for more information. Treatment may be refused if it isn’t considered in your own interest to proceed.

**Advised consent**

I confirm that I have been fully informed about the product/s and procedure…

The product is injected into the dermis to correct wrinkles, folds and lines of the face and skin, or for lip augmentation. You should be aware that the combination of the product with certain drugs that reduce or inhibit hepatic metabolism (cimetidine, beta-blockers etc.) is inadvisable. You should be made aware that this product contains 0.3% lidocaine that may produce a positive result in anti-doping tests. Due to the use of a needle, there is likely to be some bleeding at the injection site. Reactions, such as, swelling and redness may occur after the injection and this may be associated with stinging, itching or discomfort upon pressure at the injection site. This reaction may last for several days. Rarely, discolouration of the injection site, necrosis, abscess formation, granulomas, hypersensitivity and haematomas have been reported. Indurations or nodules may develop.

If any of these symptoms persist for more than one week, or if any other side effects develop, please report them to your practitioner as soon as possible. They will then be able to advise on the best course of action. Whilst rare, such side effects and their treatment may last for several months.

The aesthetic effect of the product last for up to 12 months but will vary depending on the condition of the skin, area treated, amount of product injected, injection technique and lifestyle factors, such as sun exposure and smoking.

The average life of treatment on the lips is less than in other areas because of the high vascularization and action of the lip area. A touch-up procedure may be required 1-3 weeks after the first injection and helps to optimize the results and maximize their duration.

After treatment, avoid extreme facial expressions, alcohol and make-up for up to 12 hours. Also avoid sun exposure, UV light, freezing temperatures and saunas for 2 weeks after treatment.

My treating practitioner has…

* Provided me with sufficient information about the treatment to allow me to make an informed decision.
* Given me the opportunity to ask any remaining questions I have about the treatment and has answered them to the best of their ability.
* Given me time to consider the treatment.
* Received the relevant medical history information from me to the best of my knowledge.

I therefore consent to receiving the described treatment by my practitioner.

Signed:

Date: