PLASMA-FIBROBLAST CONSULTATION FORM

Please complete the following information to maximise the effectiveness of the treatment and ensure your safety. Please answer all questions and sign below. All information given is treated as confidential.

Name: Mr/Mrs/Miss/Ms	D.O.B:	Male □ Female □
Address:		
Postcode:	Suburb:	
Phone: (Home)	M:	W:
Email:		
GP Name and Address:		

Please read carefully and answer each section

(the more we know about your health the better we can service your needs)

1. Tick any of the following allergies that apply:

□ Lanolin □ Latex Gloves □ Medical Tape □ Novocaine/Lidocaine

□ Metals □ Foods □ PABA (Para-aminobenzoic acid/Folic Acid Vitamin)

□ Medications / Drugs _____

□ Other allergies _____

2. Tick any of the following that apply:

□ Glaucoma □ Contact lenses □ Conjunctivitis (pink eye) □ Cataracts □ Dry Eyes

□ Alopecia □ Blurred Vision □ Eye Makeup sensitivities □ Trichotillomania (pull out eyelashes and brows compulsively)

□ Eyebrow tinting - Date of last service _____

□ Eyelash tinting - Date of last service _____

□ Other Eye Disorders/Conditions _____

□ When was the last time you visited a dentist? _____

□ Chapped lips □ Cold Sores/Herpes □ Ulcers

Are you taking medication for any of the mouth /lips conditions above? _____

What type of medication are you taking? _____

□ Collagen Injections □ Botox □ Other anti-aging fillers

Please name the anti-aging filler _____(eg.fat transfer injections)

Name the area which has been filled _____(eg.lips, cheeks, eyes, forehead etc.)

What was the date these treatments were performed? _____

3. Please tick all of the following that apply:

□ Any other tattoos. Location of tattoo/s_____Age tattoo/s_____

□ Piercings. Where? _____

□ Use of a tanning bed, suntan outdoors □ Are currently tanned in the area to be treated

□ Currently using Retin A or other skin thinning lotions or creams. Where? _____

□ Currently using Glycolic Acid or other AHA products: _____

□ Had a chemical peel. When? _____

□ Do you have a scar you want softened/camouflaged? Where? Age of scar _____

□ Any keloid or hypertrophic scars? Where? _____

□ Bruise or bleed easy
□ Prolonged bleeding
□ Healing problem
□ Polycystic ovaries
□Irregular Periods
□Diabetes
□ Thyroid
□ Eczema
□Dermatitis
□Psoriasis
□ Active Acne
□ Cystic Acne
□Pigmentation
□ Moles/warts/Skin Tags
□Rosacea
□ Sunburn in treatment area

□ Skin Cancers - Where? _____Treatment_____

Describe: _____

4. Please tick all of the following that apply

□ Do you smoke? □ Yes □ No
□ Epilepsy
□ High Blood Pressure
□ Low Blood Pressure
□ Asthma/Breathing difficulty
□ Uncontrolled Diabetes or Diabetes
□ Currently on blood thinners
□ Anxiety/Stress/Nervousness
□ Thyroid abnormalities
□ Hemophilia or other clotting disorders
□ Heart palpitations/Conditions
□ Mitral valve prolapse or valve implants
□ Metal parts in the body. Where?
□ Taken Roaccutane in the last 6 months
□ Pregnant or trying or breast feeding a baby
□ Seizures
□ Auto Immune Disorders
□ HIV □ Yes □ No
□ Hepatitis □A □B □ C

□ Blood transfusion. When? _____□ Cancer/Luekemia (within the last 3 years)

Treatment? Give Details _____

□ Recent surgeries (last 12 months) Describe: _____

□ Future surgery Please describe (eg. cosmetic or other surgery) _____

5. Please list any medications, prescription and nonprescription, that you may have taken in the last 2 weeks_____

If under a physicians care for any condition, please describe_____

6. Areas of Application

□ Age-Warts (Seborrheic keratoses)
□ Fibromas (Predunculated wart)
□ Skin-Coloured Nevi (Dermal nevi)
□ Viral Warts, Age Spots (Lentigines)

□ Light Damaged Skin (Actinic precancerous)
□ Fat Deposits under the skin of eyelids (Xanthelasms)
□ Eyelids/Crow's Feet Lifting
□ Nasolabial Lin
□ Mid-Face/Cheeks Lift
□ Skin Tags Removal
□ Scars, Acne Scars
□ Wrinkle Smoothing
□ Neck Lifting
□ Marionette Line
□ Glabella/Forehead
□ Mole Removal

7. Risk: even if the therapy is carried out in the correct manner there are certain risks, which are listed below:

□ Intolerance of the local anaesthetic (cream form or local injection)
□ Wound infection
□ Wound healing disorders
□ Scarring (extremely rare)
□ Pigment disorder (hyper hypopigmentation) / a sunscreen with a high filter SPF 50 should be used for at least 8 weeks after the treatment.

8. Declaration

Declaration of Consent for Plasma-Fibroblast Treatment

I have been personally advised by the Plasma-Fibroblast practitioner about the type, kind and purpose of the treatment, including information about possible anesthetization. I was thoroughly informed about the required behaviour, as well as the necessary sun protection before and after the treatment and pointed out possible complications before and after the treatment. In doing so, my personal situation was sufficiently discussed, as well as realistic treatment results. I have understood the general information for the patient on treatment and after-treatment which was explained by Plasma-Fibroblast practitioner. I was also able to ask all the questions I was interested in. These were answered and understood by me i.e; Specific personal risk factors of the patient (medication, allergies, operations, sensitivity, disorders).

YES □ **NO □**

I am aware that a guarantee cannot be given for the results of the treatment. I have also been informed about the necessity of additional treatments (fee required), which may be necessary to achieve the desired results. Nevertheless, I agree to carry through with the above described treatment. I have been given sufficient time and opportunity to think about my decision and I do not have any further questions have been answered completely and thoroughly understood. I have received and read the patient information. I will follow the instructions. I agree to the Plasma Treatment sufficient time for consideration. I agree to the procedure with the Plasma Treatment immediately and waive a 24-hour consideration period.

This history form has been read, understood and signed herein, and all of my questions in regards to my treatment have been answered satisfactorily. I am over 18 years of age, and if not have presented a parental name and authorization signature below to perform the treatment. I understand and have had explained to me proper home care treatment for my procedure. I understand that these procedures may produce some swelling, redness, itching, discomfort, numbness and adverse side effects. I understand that the treatment I have chosen is for cosmetic purposes only and no guarantees have been made to me concerning the results of the procedure. I understand that the results achieved, and number of treatments required will differ from person to person.

Client Name: Client Signature: Date:

Parental Name: Parental Signature: Date:

Aesthetician Name: Aesthetician Signature: Date:

Avana Clinic's Aftercare Leaflet Signed and Received by Client.

Client's Name: Client's Signature: Date:

Official Use

Practitioner Note

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