DERMA® 2.0

by Fountain of Youth Aesthetic Boutique

CONSULTATION

Name:

DOB:

D D M M Y Y Y Y

Address:

Telephone Number:

Email:

Emergency Contact & Tel. Phone No.

Regular Doctor & Tel. Phone No.

What are your expectations from your treatment?

Are you currently pregnant or breastfeeding? Y N

Do you smoke? Y N
If Yes, how many per day? _____

Do you drink alcohol? Y N
If Yes, how many units per week? _____

Do you bruise or bleed easily? Y N

Have you had a dental block or used topical numbing cream previously? Y N

Have you received your COVID19 injections? Y N

Do you have a history of a severe allergy/anaphylaxis? Y N

If Yes, please give details

Are you currently receiving any medical treatment or recently had surgery? Y N

If Yes, please give details

Are you taking any prescription medication, over-the-counter medication, supplements or herbal remedies? Y N

If Yes, please give details

Have you taken Oral/Topical Retinoids, St John's Wort, Amiodarone, Minocycline, Anticoagulants or Oral/Topical Steroids within last 6 months? Y N

If Yes, please give details

Do you have any known allergic reaction?
(e.g. Hyaluronic Acid, Antibiotics, Liodcaine, Latex, Metal, Dyes etc.) Y N

If Yes, please give details

Have you had any previous surgery or plan to? Y N

If Yes, please give details

Have you previously received any Aesthetics or Beauty Treatments?
(e.g. Botulinum Toxin, Dermal Fillers, Laser, Skin Peels, Dermabrasion etc.) Y N

If Yes, please give details

Please Check all that apply

- [ ] Cancer
- [ ] Neoplastic Diseases
- [ ] Liver Disease
- [ ] Lung Problems
- [ ] Organ or Tissue Transplants
- [ ] Heart Condition/ Disease
- [ ] Stroke
- [ ] High/Low Blood Pressure
- [ ] Metal Stents
- [ ] Implanted Electrical Devices
- [ ] Muscular Dystrophy
- [ ] Eaton Lambert Syndrome
- [ ] Multiple Sclerosis
- [ ] Myasthenia Gravis
- [ ] Amyotrophic Lateral Sclerosis
- [ ] Porphyria
- [ ] Bell's Palsy
- [ ] Epilepsy or Myasthenia
- [ ] Convulsions
- [ ] Stomach Ulcers
- [ ] Hepatitis
- [ ] Thrombocytopenia
- [ ] Hemorrhagic or Bleeding Disorder
- [ ] Hypofibrinogenemia
- [ ] Thrombosis/Varicose Veins
- [ ] Phlebitis
- [ ] Pulmonary Embolism
- [ ] Sepsis
- [ ] Diabetes
- [ ] Hypoglycemia
- [ ] Hypokalemia
- [ ] Thyroid Problems
- [ ] Aplastic Anemia
- [ ] Burns/Skin Grafts
- [ ] Platelet Dysfunction Syndrome
- [ ] Hormonal Disorders
- [ ] Acute or Chronic Infections
- [ ] Hirsutism or Polycystic Ovaries
- [ ] Rheumatic Fever
- [ ] Joint or Muscle Problems
- [ ] Asthma
- [ ] Bronchitis
- [ ] Hay Fever
- [ ] Leber's Disease
- [ ] Glaucoma/Cataracts
- [ ] Lipodystrophy
- [ ] Depression
- [ ] Migraine
- [ ] Oedema/Water Retention
- [ ] Aplastic Anemia
- [ ] Myeloproliferative Disorders

Any other medical issues not listed above? ○ Y ○ N

If Yes, please give details

Please Check all that apply

- [ ] Fine Lines & Wrinkles
- [ ] Loss of Volume
- [ ] Sagging Skin
- [ ] Dehydrated Skin
- [ ] Dull Skin
- [ ] Sensitive Skin
- [ ] Photodamage
- [ ] Broken Capillaries
- [ ] Hyper/Hypo Pigmentation
- [ ] Melasma
- [ ] Acne/Acne Scarring
- [ ] Hypertrophic/Keloid Scaring
- [ ] Psoriasis
- [ ] Dermatitis or Eczema
- [ ] Rosacea

I CONFIRM I HAVE ANSWERED THE ABOVE CORRECTLY AND HONESTLY TO THE BEST OF KNOWLEDGE

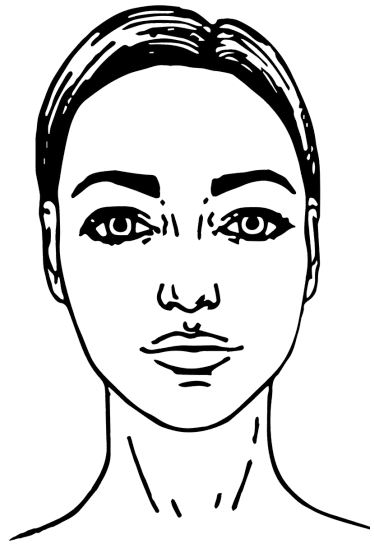
I understand this is an elective procedure and I hereby voluntarily consent to treatment. The risks have been explained to me and I accept the risks of the treatment. I certify that I am over 18 years of age, I am not under the influence of alcohol or drugs and I am not pregnant or breastfeeding. All my questions have been answered satisfactorily and I understand it is important to follow all aftercare instructions given to me.

X Patient Signature _____

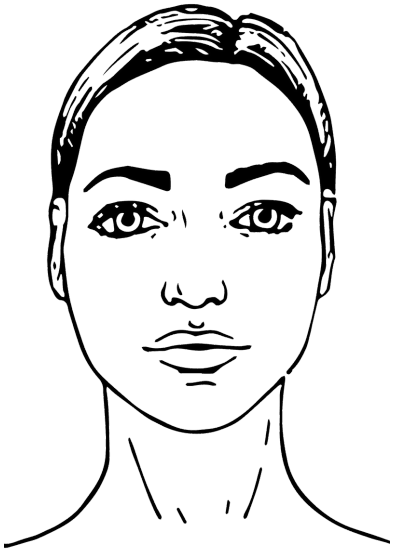
X Patient Full Name_____

X Date _____

TREATMENT RECORD



Notes.



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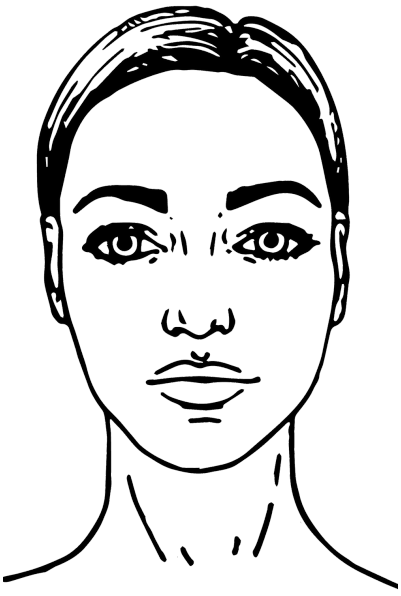

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