



JUVEDERM

Name _____ Address _____

City _____ State _____ Zip _____

Home Phone _____ Work/Cell Phone _____

Primary Physician's Name _____ Phone# _____

DOB ____/____/____ Age _____ Height _____ Weight _____

Please list all the medications you are currently taking: _____

Allergies: _____ Are you on antibiotics at this time: _____

Please Circle any of the following conditions you currently have or had in the past:

- | | | | |
|---------------------|---------------|------------------|---|
| Cold Sores (Herpes) | Facial Rashes | Pregnant/Nursing | Muscle Weakness |
| Numbness | Anaphylaxis | Severe allergies | Allergic to gram positive bacteria proteins |

List and/or explain other Medical Conditions not listed:

Previous Hospitalizations/Operation: _____

Have you had plastic surgery or other surgery to your face/neck areas when?

Had Juvederm Injections before: _____ Last Treatment? _____

What areas? _____, _____, _____

Were you happy with previous *Juvederm* treatments? _____

Explain _____

Areas of special concern? _____

I understand the information on this form is essential to determine my medical and cosmetic needs and the provision of treatment. I understand that if any changes occur in my medical history/health I will report it as soon as possible. I have read and understand the above medical history questionnaire. I acknowledge that all answers have been recorded truthfully and will not hold any staff member responsible for any error or omissions that I have made in the completion of this form.

Patient Signature _____ Date _____

JUVEDERM™, RESTYLANE®

PRE-TREATMENT

Discontinue any anti-inflammatory drugs (Ibuprofen, Motrin, Advil, Aleve, Vioxx, etc.), aspirin, high doses of Vitamin E, or Ginko Biloba one week prior to treatment. This will reduce the possible side effects of bruising and/or swelling in the treated area(s).

It is also preferable to discontinue Retin-A two (2) days before and two (2) days after treatment.

Consumption of alcoholic beverages, caffeine, spicy foods, garlic and cigarettes within 48 hours prior to treatment can increase the chances of bruising and/or swelling.

You cannot be pregnant or breastfeeding to receive treatment.

If you have a history of oral herpes, cold sores and/or fever blisters, you MUST pre-treat with an anti-viral three days before and after your scheduled visit.

If you develop a cold sore, blemish, or rash, etc. in the area to be treated prior to your appointment, you must reschedule your appointment once the problem has resolved.

If you have a special event or vacation in the near future, it is advisable to schedule your treatment at least two (2) weeks in advance.

POST-TREATMENT

After your treatment it is normal to have some redness and swelling that may last up to 7 days. Cold compresses may be used immediately after treatment to reduce swelling.

Avoid touching the treated area for 6 hours following treatment. After that, the area can be washed gently.

You may also massage the treated area to smooth any lumpiness. Sunbathing and cold outdoor activities should be avoided until redness and swelling disappear.

If you have previously suffered facial cold sores, there is a risk that the needle punctures could contribute to a recurrence. Dr. Hall can prescribe medication to minimize a recurrence.

Avoid exercise and alcohol for 6 hours after treatment.

Before the product has fully dissipated, you will want to schedule your next appointment for 6 to 9 months later than your initial treatment or as recommended by Dr. Hall to maintain your refreshed appearance.

Restylane, Juvederm Consent Form

What are fillers?

Fillers that are used are lab-produced (not animal or human derived) gels that correct moderate to severe facial wrinkles and folds.

How are they applied?

Ice and numbing medicine will be used to reduce discomfort of the injection.

The gel is injected with a fine needle under the skin surface.

Multiple injections may be made depending on site and depth of wrinkle.

Injector will gently massage the correction site to conform to the contour of surrounding tissues.

At a later date, additional treatments may be necessary to achieve the desired level of correction.

Periodic touch-up injections help sustain the desired level of correction.

Possible Side Effects may include, but are not limited to:

Mild swelling and pain

Mild itching at injection site

Discoloration of the skin

Bruising (made worse by blood thinners such as Advil, Motrin, Coumadin, Plavix)

Infection

Visible lumps temporarily following the injection, Pruitis, Nodules

Fillers should NOT be used if:

You have had severe allergies to previous injection of same product

Site currently has an active inflammation or infection such as cyst, pimple, rash or hives

You have **RECENTLY** had laser treatment or chemical skin peels on the face

After the Treatment

Fillers are not a "cure-all" for aging changes, and there is NO guarantee that wrinkles or folds will completely disappear. You may require additional treatments to achieve the results you seek.

Additional treatments required in 6 to 9 months for a continued effect.

CONSENT

By signing this form, you indicate that:

This procedure is strictly voluntary

You hereby authorize Dr. Hall to perform a Facial Augmentation and Filler Injection(s).

The nature, purpose, and complications of this procedure have been explained to your satisfaction.

No guarantee has been given as to the results that may be obtained with this treatment.

You have read this entire document and fully understand its contents.

X _____ Date _____
Signature of Patient

X _____ Date _____
Signature of Witness