107 West 15th St. • Hays, KS
(785) 639-1873

body + soul
A DAY & MED SPA

www.bodyandsoulhays.com
Body+Soul Day and Med Spa

Consent for use of JUVEDERM™ and JUVÉDERM™ Ultra

INDICATIONS

JUVEDERM™ and JUVÉDERM™ Ultra injectable gel are injected into areas of facial tissue where moderate to severe facial wrinkles and folds occur. It temporarily adds volume to the skin and subcutaneous tissues, may give the appearance of a smoother skin surface and may help smooth moderate to severe facial wrinkles and folds.

Correction is temporary; therefore, touch-up injections as well as repeat injections are usually needed to maintain optimal correction. Less material (about half the amount) is usually needed for repeat injections. Most patients need one or possibly two treatments to achieve optimal wrinkle smoothing. The results may last as long as 9 months to 1 year.

ALTERNATIVES

Other treatments for dermal soft-tissue augmentation include but are not limited to, products such as Radiesse, Restylane, Hylaform, Cosmoderm and Perlane. Aside from these treatments, additional options for the correction of lines and wrinkles do exist, including facial creams, BOTOX® Cosmetic (Botulinum Toxin Type A), chemical peels, and laser skin surface treatments, and surgery. Other options not mentioned here may exist. All options should be discussed with your physician.

SIDE EFFECTS AND COMPLICATIONS

Most side effects are mild or moderate in nature, and their duration is short lasting (7 days or less). The most common side effects include, but are not limited to, temporary injection-site reactions such as: redness, pain/tenderness, firmness, swelling, lumps/bumps, bruising, itching, infection and discoloration.

In the first 24 hours after injection, you should avoid strenuous exercise, extensive sun or heat exposure, and alcoholic beverages. Exposure to any of the above may cause temporary redness, swelling, and/or itching at the injection sites. If there is swelling, you may need to place an ice pack over the swollen area. You should ask your physician when makeup may be applied after your treatment. Be sure to report any redness and/or visible swelling that lasts for more than a few days, or any other symptoms that cause you concern.

CONTRAINDICATIONS

JUVEDERM™ and JUVÉDERM™ Ultra injectable gel should not be used if you have:
· Severe allergies marked by a history of anaphylaxis or history or presence of multiple severe allergies
· A history of allergies to Gram-positive bacterial proteins

The following are important treatment considerations for you to discuss with us and understand in order to help avoid unsatisfactory results and complications:

- **Please inform us prior to treatment:** If you are using substances that can prolong bleeding, such as aspirin or ibuprofen, as with any injection, may experience increased bruising or bleeding at the injection site.
- **Please inform us prior to treatment:** If you are on immunosuppressive or therapy used to decrease the body's immune response, as there may be an increased risk of infection
- **Please inform us prior to treatment:** If you are pregnant or breastfeeding,
- **Please inform us prior to treatment:** If you have history of excessive scarring (e.g., hypertrophic scarring and keloid formations) and pigmentation disorders.

If laser treatment, chemical peeling, or any other procedure based on active dermal response is considered after treatment with JUVEDERM™ and JUVÉDERM™ Ultra injectable gel, there is a possible risk of an inflammatory reaction at the treatment site The safety and effectiveness of JUVEDERM ™ and JUVÉDERM™ Ultra injectable gel for the treatment of areas other than facial wrinkles and folds (such as lips) have not been established in controlled clinical studies. Use in patients under 18 years has not been established.

PATIENT'S ACCEPTANCE OF RISKS

I have read the above information and have discussed it with my physician. I understand that it is impossible for the doctor to inform me of every possible complication that may occur. No guarantees about results have been made. By signing below, I agree that my doctor has answered all of my questions and that I understand and accept the risks, benefits, and alternatives of JUVEDERM™ and JUVÉDERM™ Ultra.

_____ _____

Patient Signature ***Date***

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MEDICAL HISTORY FORM

Last Name: _____ First Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Email Address: _____

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 <u>ANY</u> current or chronic medical illnesses?** *Disclose any history of heat urticaria (hives) diabetes, autoimmune disorders or any immunosuppression, blood disorders, cancer, bacterial or viral infections, medical conditions that significantly compromise the healing response, skin photosensitivity disorders, neuro-muscular disease, diabetes, coldsores/fever blisters, mental disease, or <u>ANY</u> other condition or illness.* Please list: _____ _____	☐	☐
2.	**Do you have <u>ANY</u> 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: _____ _____	☐	☐
3.	**Have you ever had any surgeries?** Please list: _____ _____	☐	☐
4.	**Are you currently under a doctor's care? If so, for what reason?** _____	☐	☐

		YES	NO
5.	**Do you take/use <u>ANY</u> medications (prescription & nonprescription), vitamins, herbal or natural supplements, on a regular or daily basis?** Please list: _____	☐	☐
6.	**Are there any topical products (both medical and non-medical) that you use on your skin on a regular or daily basis?** Please list: _____	☐	☐
7.	**Do you take/use <u>ANY</u> systemic/oral steroids (e.g.: prednisone, dexamethasone)?** Please list: _____	☐	☐
8.	**Do you have <u>ANY</u> allergies to medications, foods, latex or other substances?** Please list: _____	☐	☐
9.	**Do you smoke?**	☐	☐
10.	**Do you drink? If yes, how many drinks per week?** _____	☐	☐
11.	**Do you exercise? If so, please circle one:** rarely frequently daily	☐	☐
12.	**(For women) Are you or could you be pregnant?**	☐	☐
13.	**(For women) Are menstrual periods regular, or have you ever been diagnosed with Polycystic Ovarian Disorder?**	☐	☐
14.	**Do you have a history of herpes I or II in the area to be treated?**	☐	☐
15.	**Do you have a history of keloid scarring or hypertrophic scar formation?**	☐	☐
16.	**Do you have a history of light induced seizures?**	☐	☐
17.	**Do you have any open sores or lesions?**	☐	☐
18.	**Do you have any history of radiation therapy in the area to be treated?**	☐	☐
19.	**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?** Please list product name and date last used: _____	☐	☐
20.	**In the last three (3) months, have you used any of the following products: glycolic acid or other alphahydroxy or betahydroxyacid acid products: exfoliating or resurfacing products or treatments?** Please list product name and date last used: _____	☐	☐
21.	**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.?** If yes, please list locations on or in the body and dates: _____	☐	☐
22.	**Do you have or have you ever had any Botulinums, such as Botox® or Dysport®?** If yes, please list locations on or in the body and dates: _____	☐	☐
23.	**Have you taken Accutane® (or products containing isotretinoin) in the last 12 months?**	☐	☐
24.	**Have you taken Tretinoin (like Retin-A®, Renova®) in the last 6 months?**	☐	☐
25.	**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?**	☐	☐

THE ABOVE INFORMATION IS TRUE AND ACCURATE TO THE BEST OF MY KNOWLEDGE.

Signature: _____ ***Date:*** _____