MV Makeup & Skin Care

RF FIRMING AND CONTOURING FACIAL CONSENT FORM

Name: _____ Date of Birth: _____
Address: _____ City: _____
State: _____ Zip: _____
Cell Phone: _____ Home Phone: _____ Email Address: _____

SKIN TYPE: Review the skin types below, using the Fitzpatrick Scale, and check the one that best describes your skin. This information will be used by your technician to determine the most appropriate way to approach your treatment(s):

_____I. Very fair skin; blonde or red hair; light-colored eyes; freckles common
_____II. Fair skinned; light hair, light eyes
_____III. Very common skin type; fair; eye and hair color vary
_____IV. Mediterranean Caucasian skin; medium to heavy pigmentation
_____V. Mideastern skin; rarely sun sensitive
_____VI. Black skin; rarely sun sensitive

Are you of Asian heritage (Class V) and/or have a history of keloid scarring? Yes or No (Circle One)

Please list the products you use regularly:

Facial Cleanser _____ Moisturizer _____ Toner _____
Serum _____ Scrubs _____ Sunscreen _____
Retinol _____ Glycolic Acid _____ Enzymes _____
Peptides or Growth Factors _____

Cosmetic History

How would you describe your skin? Normal ____ Combination ____ Oily ____ Dry ____
When were you last exposed to the sun (including tanning beds)? _____
Do you use sunless tanning products? Yes _____ No _____ If yes, when was it last applied? _____
Have you ever had treatments for vascular veins, pigmented lesions, or other unwanted lesions? Yes _____ No _____
If yes, when? _____ What body area(s) were treated? _____
Describe your experience _____
Have you had chemical peel treatments in the past? Yes ____ No ___ If yes, when? _____
Describe your experience _____

Are you currently using, or have you used in the past year, any of the following? Yes (circle one) ___ No ____

Isotretinoin (Accutane)	Tretinoin (Retinoic Acid)	Acyclovir	Glycolic Acid	Salicylic Acid
Adapalene (Differin)	Hydroquinone	Azelaic Acid	Lactic Acid	Spironolactone

If yes, when? _____

Are you using any topical creams, lotions, or oral antibiotics for acne, skin cancer, antiaging or hyperpigmentation? Please List:

_____

Have you ever had any of the following injectables or implants?

Botox	Juvederm	Radiesse	Restylane	Perlane	Silicone
Collagen	Sculptra	Dysport	Other: _____		

If yes, when? _____ What body area(s)? _____

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Have you had any facial cosmetic surgeries/procedures, piercings, metal implants, tattoos, or use of a pacemaker within the past year?
Yes _____ No _____ If yes, when? _____
Have you had any laser resurfacing treatments in the past six weeks? Yes _____ No _____ If yes, when? _____
Have you used any of the following hair removal methods in the past six weeks? Shaving _____ Waxing _____ Electrolysis _____
Tweezing _____ Threading _____ Depilatories _____

Health History

Do you have hyperpigmentation (darkening of the skin) or hypopigmentation (lightening of the skin) or marks after physical trauma?
Yes _____ No _____ If yes, describe _____
Do you form thick or raised scars from cuts or burns? Yes ___ No ___
Have you had chemotherapy in the past 6 months? Yes _____ No _____
Do you have any allergies to medications, food, latex, topical products, and/or other substances? _____
_____

Do you have any of the following conditions?
Epilepsy _____ Pregnancy and/or breastfeeding _____ Autoimmune disease _____ Herpes Simplex _____ Diabetes
Dental implants, crowns, metal fillings _____ Pacemaker or internal defibrillator _____
Implanted neuro stimulators or other internal electric device _____
Metal implants or other implants in the treatment area, i.e. IUD, screws, plates _____
Varicose veins _____ History of skin disorders _____
Do you have a history of Erythema Ab Igne (EAI), a persistent skin rash produced by prolonged or repeated exposure to moderately intense heat?
Yes _____ No _____
Do you have any other health condition not mentioned here? Yes ___ No _____
If yes, please list. _____
Have you consumed drugs or alcohol in the last 24 hours? Yes _____ No _____
Have you undergone any recent surgery? Yes ___ No _____
If yes, please explain _____
Please list all vitamins and supplements including herbal remedies you take regularly _____
_____
Please list all current medications including aspirin, ibuprofen, blood thinners, etc. you take regularly _____
_____

Is there anything else you would like us to know? _____
_____

Please be aware of the following information and possible risks. Please initial:
_____ I understand that the use of Botox®, Juvederm®, Restylane®, and any other injectable must be disclosed prior to treatment.
_____ I understand that it is imperative to my health that I disclose all of the information requested in the Client Profile/Health History.
_____ I have cited all conditions and circumstances regarding my health history, medications being taken, and any past reactions to products or medications.
_____ I understand that additional conditions could occur or be discovered during the procedure which could affect my ability to tolerate the procedure.
_____ I consent to “before and after” photographs for the purpose of documentation, potential advertising and promotional purposes.

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_____ I understand that if I have any concerns, I will address these with my skin care specialist. I give permission to my skin care specialist to perform the microcurrent procedure we have discussed and will hold him/her and his/her staff armless and nameless from any liability that may result from this treatment. I have accurately answered the questions above, including all known allergies, prescription drugs, conditions, or products I am currently ingesting or using topically. I understand my skin care specialist will take every precaution to minimize or eliminate negative reactions as much as possible. In the event I may have additional questions or concerns regarding my treatment, I will consult the skin care specialist immediately. I agree that this constitutes full disclosure, and that it supersedes any previous verbal or written disclosures. I certify that I have read, and fully understand, the above paragraphs and that I have had sufficient opportunity for discussion to have any questions answered. I understand the procedure and accept the risks. I do not hold the skin care specialist, whose signature appears below, responsible for any of my conditions that were present, but not disclosed at the time of this procedure, which may be affected by the treatment performed today.

_____ I certify that the preceding medical, personal, and skin history statements are true and correct. I am aware that it is my responsibility to inform the esthetician of my current medical or health conditions and to update this history. A current medical history is essential to execute appropriate treatment procedures.

Client's Name (Please print legibly): _____

Client's Signature: _____ Date: _____

Parent/Legal Guardian (If Client Is Under 18): _____

Parent/Legal Guardian's Signature: _____ Date: _____

Practitioner statement: I have personally reviewed the above information with my client or the client's representative.

Practitioner's Name: _____

Practitioner's Signature: _____ Date: _____