HEALTH HISTORY FORM

Name:_____ DOB:_____ Date:_____

Address:_____ City_____ State:_____ Zip:_____

Phone #:_____ Email:_____ Employer:_____

Emergency Contact Name & Phone #:_____ How did you hear about us?_____

Are you currently under the care of a physician?____yes ____no If so, for what?_____

Physician's name:_____ Physician's phone #:_____

Date of last lab tests or chemistry screening_____ Have you had abnormal lab / test results? ____yes _____no

If so what?_____ Covid? ____yes _____no Vaccine?____yes _____no

Have you ever had injectables, facial treatments or tattoos? _____yes _____no Did you have negative reactions? ____yes _____no

If so what?_____ Allergies:_____

List all current medications:_____

List all supplements /herbs:_____

•Treatment is limited on those who are pregnant, nursing, or have hemophilia, bleeding disorders, allergies to lidocaine &/or epinephrine.
____ this does apply to me ____ this does not apply to me

•Treatments are discouraged for those who have auto-immune disorders, diabetes, heart conditions, active dermatological disorders, are highly reactive and allergic, or take medication(s) that thin the blood. These clients may need a doctor's release to undergo procedure.
____ this does apply to me ____ this does not apply to me

•For some injectables and permanent cosmetics, patch tests are recommended but are mandatory for those with keloid formations, dermatological disorders, and are highly reactive and allergic. ____ this does apply to me. ____ this does not apply to me

•List all medications you are currently taking including topical medications and Retin A, Retinol, Glycolic Acid & Accutane:

_____

•Have you recently undergone a skin peel, laser, botox, or other esthetics treatment(s)? If so, please describe:

_____

•Do you have, or have ever had, any of the following? Please circle

Heart conditions /disease	Cold sores (RX:VALTREX)	Herpes simplex	Pregnant /Breastfeeding	G6PD Deficiency
Hemophilia / bruising	Epilepsy	Glaucoma (NO EYELINER TX)	Mental Disease	Hyperpigmentation
High/low blood pressure	Diabetes	Cataracts	Parathyroid problems	Tanning Bed &/or Sun
Prolonged bleeding	Fainting or Dizziness	Corneal abrasion	Strokes	Skin disorders
Circulatory problems	Lupus or other immune disorders	Optic Nerve Atrophy or Leber's Disease	Nuero-Muscular Disorder	Recreational drugs What:_____
Tumors/growths/cysts	Hepatitis	Wear glasses or contacts	Sarcoidosis	Smoke / Tobacco
Chemotherapy/radiation	HIV/ AIDS	Eye surgery / injury	Sickle Cell Anemia	Drink alcohol daily
Cancer	Kidney disease or stones	Asthma	Liver Disease	Other:
High Magnesium	High Calcium	Low Potassium	High Iron	

I understand all questions and have answered honestly and am at least 18 years of age ____Yes ____No

Signature:_____ Date:_____

Staff Signature:_____ Date:_____

HIPPA Notice of Receipt of Privacy Practices

I acknowledge that I have been informed and given access to the Notice of Privacy Practices at Monarch Medical Esthetics.

I understand that I may request a hard copy of these notices at any time.

I understand the Notice of Privacy Practices discusses how my Protected Health Information (PHI) may be used/or disclosed, my rights to protected health information, and how and where I may file a privacy related complaint.

Signature:_____ Date:_____

Authorization to Release and Disclose Photographs

I _____ give permission for photographs / videos to be taken of all treatment and treatment sites, which will be used to document my medical record or for use in educational/training lectures. (patient initials)_____

I also give my permission and voluntarily consent to the copyright, publication, and use of my picture and likeness by Monarch Medical Aesthetics LLC., affiliates, successors, and assignees. By signing this form, I am allowing Monarch Medical Aesthetics to disclose photographs taken of me before, during, and after treatment for use in, but not limited to, educational/ training lectures, advertising and promotions, print, social and/or broadcast media. I understand my name shall not be used in any publication.
(patient initials)_____

Do not use my pictures outside of use in my medical records and educational/training lectures. (patient initials)_____

I hereby release Monarch Medical Aesthetics LLC., from any claim for payment in royalties in connection with any exhibition, demand, cause, action, or proceeding of whatever nature arising out of publication and distribution of these said photographs in accordance with the terms of this release. (patient initials)_____

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Beautiful Change.

HOLD HARMLESS AGREEMENT

I, _____, hereby acknowledge that I am fully aware that MONARCH MEDICAL AESTHETICS, LLC and AMY STITT (Nurse Practitioner) provide the service of (but not limited to) neurotoxin, derma-filler, PRP/PRF injections, and hair regrowth treatments and MONARCH MEDICAL AESTHETICS, LLC and LINDA R MOORE (Technician) provide the service of permanent cosmetics and MONARCH MEDICAL AESTHETICS, LLC and SARAH ANDERSON (Aesthetician) provide the service of a variety of facial and body treatments.

It is understood that I will in no way hold the above named, its proprietors, officers, or agents or any of its operators liable or accountable for any injury or damage that may occur to me as a result of work performed on me by the nurses/ aestheticians / technicians/owners of MONARCH MEDICAL, hereinafter "staff," has fully explained and given all the information necessary regarding possible side effects and contraindications.

I, the undersigned and the person named above, hereinafter referred to as client, have been duly informed by staff of the nature, risk and possible complications and consequences of the treatments and procedures for which I have contracted Monarch and staff to provide such service. I understand that this procedure is designed to enhance my appearance and consent to such treatment, which shall be performed by, or under the direction of staff.

I further understand that if I am being used as a model for training purposes at a reduced fee and agree to hold technician, Monarch Medical and its proprietors harmless in the event of any consequence arising out of this procedure.

I have been advised and I fully understand that improper pre-procedure and post-procedure care may lead to complications / infections / less than ideal outcome. Staff has given me these instructions, which I am to carefully follow. I acknowledge that should infection and complications occur due to improper skin care and improper following of instructions, I will hold staff, MONARCH MEDICAL and its proprietors harmless.

I have read and understand all the pre and post procedure instructions and I have truthfully and accurately completed my health history form.

Client: _____ Date: _____

MONARCH MEDICAL ESTHETICS - FACIAL TREATMENT & LASER CONSENT

Prior to receiving treatment, I have been candid in revealing any condition that may have bearing on this procedure, such as: pregnancy (if so, consult your physician prior to treatment), recent facial surgery, allergies, tendency to cold sores/fever blisters,or use of topical and/or oral prescription medications such as: tretinoin, Retin-A®,isotretinoin, Accutane®, Differin®, Tazorac®, Avage®, EpiDuo® or Ziana®.

- I understand there may be some degree of discomfort such as stinging, pin-prickling sensation, heat or tightness.
- I understand there are no guarantees as to the results of this treatment, due variables, such as: age, condition of skin, sun damage, smoking, climate, etc.
- I understand I may or may not actually peel (with chemical peel tx) and that each case is individual and that the amount of peeling does not correlate with degree of improvement.
- I understand this treatment is a cosmetic treatment and that no medical claims are expressed or implied.
- I understand that to achieve maximum results, I may need several treatments and laser hair reduction is < 90%.
- I understand that although complications are very rare, sometimes they may occur and that prompt treatment is necessary. In the event of any complications, I will immediately contact the physician/clinician who performed the treatment.
- I agree to refrain from tanning in tanning beds or outdoors while I am undergoing treatment, and during the 14 days prior to and following the end of treatment. This practice should be discontinued due to the increased risk of skin cancer and signs of aging.
- I understand that extended direct sun exposure is prohibited while I am undergoing treatment, and the daily use of sunscreen protection with a minimum SPF of 30 is mandatory.
- I have not had any other chemical peel of any kind within 14 days of this treatment.
- I understand I cannot have another chemical peel within 14 days of this treatment, whether it is performed at this location or any other location.
- I understand that I should follow my clinician's recommendations for post-procedure skin care to minimize side effects and maximize results.
- I have accurately followed the Pre-Procedure Instructions and have completed my Health History Form and hereby agree to all of the above and agree to have this treatment performed on me. I further agree to follow all Post-Procedure Instructions as I am directed.

Patient Name:_____

Signature: _____ Date:_____

Signature of Clinician: _____ Date:_____

Date of Service	Initials	Date of Service	Initials	Date of Service	Initials

PRE-PROCEDURE INSTRUCTIONS FOR FACIAL AND LASER TREATMENTS

- Use of medical grade daily care products for 6 weeks prior to your peel will prepare your skin, allow for better treatment results and reduce the risk of complications. This is highly recommended but not mandatory.
- Do not tan or use artificial tanning products 14 days prior to treatment.
- Stop the use of Retin-A or AHA products (Alpha-hydroxy acids, lactic, tartaric, and citric acids) for 3 days prior to facial treatments.
- If prone to cold sores or fever blisters, MUST take RX Valtrex or over the counter L-Lysine 1,000 mg 1 day before procedure.
- Present to your appointment with a thoroughly cleansed face if possible.
- It is recommended makeup not be applied the day of procedure, as it is ideal to allow the skin to stabilize and rest overnight; however, makeup may be applied 15 minutes after the procedure if desired.

POST-PROCEDURE INSTRUCTIONS FOR FACIAL AND LASER TREATMENTS

Follow these instructions carefully:

- Do not wash the areas where peel solution was applied for at least 6 hours.
- For 2 days stay cool and don't sweat. Heating internally can cause hyperpigmentation.
- For 2 days do not put the treated area directly into a hot shower spray or use hot tubs, steam rooms or saunas.
- For 2 days do not apply ice to the treated area.
- For 7 days do not go swimming.
- For 7 days do not use loofahs or other means of mechanical exfoliation.
- For 7-days post-procedure do not use Retin-A or AHA products (Alpha-hydroxy acids, lactic, tartaric, and citric acids)
- For 7-days use post-procedure kit to minimize side effects and maximize results.
- For 14 days avoid direct sun exposure and excessive heat. Use SPF 30 or higher broad-spectrum UV protection conistently and regularly for healthy skin.
- Do not go to a tanning bed for at least 14 days post-procedure. This practice should be discontinued due to the increased risk of skin cancer and signs of aging.
- Do not pick or pull any loose or peeling skin. This could potentially cause hyperpigmentation.
- Do not have electrolysis, facial waxing, or use depilatories for approximately 5 days.
- After receiving a chemical peel, you should not necessarily expect to "peel". However, light flaking in localized areas for several days is typical.
- Residual redness is typical for up to 12 hours post-procedure.

By following the above instructions, you are eliminating some potential complications and ensuring a much better experience and outcome. Concerns or questions? Call Monarch Medical Esthetics 574.221.MEDI or email monarch@mybeautifulchange.com. Please allow 24-48 hours for reply. www.mybeautifulchange.com

POST-PROCEDURE INSTRUCTIONS FOR PLASMA FIBROBLAST TREATMENTS

Follow these instructions carefully:

- Anti-inflammatories such as: Advil, or anti-histamines such as: Benadryl, may be taken for mild burning sensation.
- Apply ice to the treated area to minimize and reduce swelling.
- Occasional weeping from treated areas for up to 3 days is norma and is part of the natural healing process.
- Do not scratch the area &/or pick scabbing as it can lead to infection &/or scarring.
- Always keep treated areas clean and use SPF 30 or higher for 14 days post-procedure and beyond.
- Use recommended after-care products for proper healing and to help with irritation - peeling, redness, itchiness...
- No swimming or sauna activities for 14 days post-procedure.
- Do not apply makeup to treated area until scabbing is gone.

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