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 my permission and voluntarily consent to the copyright, publication, and use of my picture and likeness by Monarch Medical Aesthetics LLC. 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. I hereby release Monarch Medical Aesthetics LLC., from any claim for payment in royalties in connection with any use of photographs.
(patient initials)_____

Do not use my pictures outside of use in my medical records and educational/training lectures. (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 neurotoxin, derma-filler and PRP/PRF injections and MONARCH MEDICAL AESTHETICS, LLC and LINDA R MOORE (Technician) provide the service of permanent cosmetics / microblading and MONARCH MEDICAL AESTHETICS, LLC and SARAH ANDERSON (Aesthetician) provide the service 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: _____

PRE & POST PROCEDURE INSTRUCTIONS FOR DERMAL FILLERS, NEUROTOXINS & FIBRIN INJECTIONS

PLATELET RICH FIBRIN, BELOTERO BALANCE®, JUVÉDERM®, JUVÉDERM ULTRA®, JUVÉDERM ULTRA PLUS®, JUVÉDERM VOLBELLA®, JUVÉDERM VOLUMA®, JUVÉDERM VOLLURE ®, RADIESSE®, RESTYLANE®, RESTYLANE DEFYNE®, RESTYLANE KYSSE® RESTYLANE LYFT®, RESTYLANE REFYNE®, RESTYLANE SILK®, & SCULPTRA AESTHETICS® DERMAL FILLER INJECTABLES

PRE-PROCEDURE INSTRUCTIONS FOR FILLERS & FIBRIN INJECTIONS

- AVOID alcoholic beverages and anti-inflammatories for 7 to 10 days before treatment including: Advil, Aleve, Ibuprofen, Aspirin, Motrin, Vitamin E, iron, and fish oil.
- START taking oral Arnica 2 days before treatment. Arnica is available to purchase at our Medispa.
  Arnika Forte: 1 capsule with water 2 times per day. Arnica: 5 tablets, 3 times per day. Dissolve under the tongue.
- APPLY Bruise Pads: Available for purchase immediately after your treatment, if desired.
- TAKE one antihistamine such as Zyrtec or Claritin for 2 days prior to your procedure, if filling the tear troughs.
- PRESENT to your appointment with clean skin free of all foundation, eye make-up, and other make-up and moisturizers. Prior to numbing, we will ask you to cleanse with one of our medical grade cleansers.
- PRE-MEDICATE with Valtrex 1 day before your procedure, if filling in or around the lips and you are prone to cold sores -REQUIRED.
- DO NOT schedule dental appointment/procedure a month before or after treatment.
- YOU MUST RESCHEDULE your appointment if you have had any infections or have been sick with a head cold, flu, COVID, sore throat, cold sore, and/or fever or have received dental treatment within the past 3 weeks.

PRE-PROCEDURE INSTRUCTIONS FOR NEUROTOXINS

- AVOID alcoholic beverages and anti-inflammatories for 7 to 10 days before treatment including: Advil, Aleve, Ibuprofen, Aspirin, Motrin, Vitamin E, iron, and fish oil.

POST-PROCEDURE INSTRUCTIONS FILLERS & FIBRIN INJECTIONS

- Bruising at the time of treatment.
- DO Take Acetaminophen/Tylenol as needed for pain or if you experience any mild tenderness or discomfort.
- DO Continue oral Arnica, Arnica Forte or Arnica Cream as needed.
- DO NOT take anti-inflammatories for 24 hours after injection.
- DO NOT massage or manipulate injection site. When cleansing your face or applying make-up, use gentle, sweeping motions to avoid excessive mobility of the area(s).
- AVOID Aspirin or Ibuprofen products, vitamin E and fish oil, as they may increase your potential to bruise.
- AVOID strenuous exercise or activity for the remainder of the treatment day. You may resume other normal activities/routines immediately.
- AVOID drinking alcohol for a minimum of 12 hours as this may contribute to bruising.
- AVOID extended UV exposure until any redness has subsided. Apply an SPF 30 or higher sunscreen to the treated area(s).
- AVOID sleeping on side for 2 nights after cheek augmentation.
- SCHEDULE 2-3 week follow-up appointment.
- If using bruise pads, leave initial pads on for 6 hours. After 6 hours, remove and apply new pads. Leave the second set of pads on for 6 hours
- Results of fillers are visible immediately after treatment. It is normal to experience swelling and bruising around the treatment area. Temporary, minimal to moderate swelling may be expected related to the area/s treated and the product/s used. This can last several days and up to 2 weeks.

-more post-procedure instructions -

- Due to tissue swelling, lumps or bumps may be visible on your face, (or on the inside of your mouth) for 2-3 weeks after filler is injected.
- It is normal to feel “firmness” in your treated area/s for the first few days after treatment. Overtime, the area(s) will soften and “settle”.
- Wait a minimum of 6 weeks before receiving any laser treatments and 1 week before skincare treatments.

The dermal filler products have been shown to provide correction in the injected sites for up to 6 to 9 months, and 18 months with touch ups. Without touch-up injections, the correction will subside gradually and the skin will look as it did before treatment.

POST-PROCEDURE INSTRUCTIONS NEUROTOXINS

- AVOID any massage or pressure to treatment area/s, as this may alter the placement of the drug.
- DO remain upright for 4 hours after injection.
- DO Contract the injected muscles every few minutes repeatedly for 1 hour after injection.
- DO NOT massage or manipulate injection site for 4 hours after injection to prevent repositioning.
- DO NOT exercise vigorously, take hot baths, avoid hot tubs, or saunas 24 hours after your treatment (sweating may compromise and dilute the product the first 24 hours after injections).
- DO NOT wear hats or head bands for the rest of the day.
- DO NOT touch injected areas for 4 hours until open areas close (hands and cell phones).
- SCHEDULE follow-up appointment in 14 days.
- After injection, edema generally subsides within minutes.
- Bruising: ice for first 24 hours, then warm packs.

Onset of response to neurotoxin treatment is highly individualized and ranges from 2 to 10 days after injection. It is common for the muscle’s action along with its associated wrinkles to return in 3 to 6 months. Repeat injections are necessary to maintain the effects received.