NEWPORT AESTHETICS

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HYDRAFACIAL MD MEDICAL HISTORY AND CONSENT FORM

HYDRAFACIAL MD® - BLUE/RED LED LIGHT THERAPY - LYMPHATIC/MASSAGE THERAPY

NAME: _____ DOB: _____

Absolute Contraindications

YES NO Accutane or other similar medication (in the past year)
YES NO Autoimmune disease, HIV, lupus, hepatitis, scleroderma
YES NO Active Infection in the treatment area
YES NO Melanoma or lesions suspected of malignancy
YES NO Active Sunburn
YES NO Pregnancy
YES NO Breast feeding / Nursing (may increase skin sensitivity & likelihood of PIH)
YES NO Epilepsy (contraindicated for LED light therapy)

Relative Contraindications

YES NO Anticoagulant / Blood thinners therapy (use lower settings)
YES NO Very thin skin
YES NO Recent: **Botox:** wait 5-7 days **Fillers**: wait 7-10 days **Peels**: wait 30 days
YES NO Laser Treatments: Wait until lesions heal & swelling & redness is resolved

Other Concerns

YES NO Keloids (avoid direct contact)
YES NO Rosacea, Telangiectasia (use lower vacuum)

If you answered **YES** to any of the above questions, please explain:

_____

Please list all current medications: _____

Please list any known allergies: _____

INFORMED CONSENT FOR HYDRAFACIAL MD TREATMENT

- I acknowledge that my skin might experience temporary irritation, tightness, or redness, which usually dissipates within 72 hours depending on skin sensitivity.
- I acknowledge that if I fail to use a minimal sunscreen (SPF 30) and follow the direction for use, I am more susceptible to sunburn, sun damage and hyperpigmentation. I should avoid excessive sun exposure, especially between 10am-2pm.
- I have disclosed my history of allergies above and I acknowledge that if I am allergic to one or more of the ingredients in the products used, I may experience an allergic reaction.
- I hereby agree to have the treatment performed and agree to follow all pre and post treatment instructions.
- I acknowledge that I have answered all questions truthfully and completely.
- I release Edge Systems, Ann Mai, MD and Affiliated Providers at Newport Aesthetics, management, and staff of Newport Aesthetics from any and all liability associated with any injuries and/or current or future conditions resulting from the skincare procedures or products.
- I consent to the use of my before, during and after facial procedure photographs for education, promotion or advertising purposes. My name will not be used to identify these photographs without my written approval.

By signing below, I certify that I have read and fully understood the contents of this consent form. The information I provided is complete, accurate, and up-to-date to the best of my knowledge.

I freely consent to the proposed treatment today as well as future treatments as needed.

Signature: _____ Date: _____

Print name: _____

Witness signature: _____ Date: _____

Print name: _____

HYDRAFACIAL MD PROCEDURE NOTE

Step 1 Precleanse. Cleansing / Exfoliation with: Active 4 with vacuum at 16 / _____. BLUE / ORANGE tip.
Step 2 Acid peel with Glysal Prep 7.5% / Peel 15% / Peel MD 30% with vacuum at 16 / _____.
Step 3 Vortex Extraction - Beta-HD with vacuum at 22 / _____.
Step 4 Vortex Fusion - Antiox-6 with vacuum at 16 / _____.
Step 5 Applied ___ Dermabuilder Home Care Serum ___ JM C-Esta Serum ___ JM Face Transformation Cream
Applied sunscreen: YES / NO ___ JM Marini Physical Protectant SPF 45 ___ Obagi Sun Shield Matte SPF 50
Add-ons: ___ Britenol ___ CTGF ___ DermaBuilder ___ LED Red / Blue ___ Lymphatic Drainage

Client tolerated procedure except no / mild / moderate redness. Treatment #: ___ Pkg? YES / NO
Client left office in good / _____ condition. Last Tx Date: _____
Repeat treatment / follow-up treatment recommended in _____ weeks / month(s).

_____

_____

_____

Clinician's Signature & Date: _____
Ann Mai, MD / Brooke Martelli, RN / Taryn Wettstead, LE / Michelle Eibl, MA