Morpheus8 Health History
Crystal's Skin & Beauty

Personal Information

NAME		HOME PHONE	
ADDRESS		WORK / MOBILE PHONE	
CITY		PROVINCE / STATE	
ZIP CODE		DATE OF BIRTH	
REFERRED BY		GENDER	MALE / FEMALE

Skin Type Assessment

FITZPATRICK SKIN TYPE	**I II III IV V VI**	ETHNICITY	
LAST EXPOSED TO UV	(SUN OR TANNING BED)		
PASSIVE TAN?	YES / NO	SELF-TANNING LOTION?	YES / NO

Medical History

PACEMAKER / DEFIBRILLATOR		ACTIVE SKIN INFECTION (E.G. PSORIASIS, ECZEMA)	
METAL IMPLANTS		SKIN DISORDERS (E.G. KELOIDS, ABNORMAL WOUND HEALING)	
CURRENT OR HISTORY OF SKIN CANCER/ OTHER CANCER / PRE-MALIGNANT MOLES		HISTORY OF BLEEDING DISORDERS	
SEVERE CONCURRENT MEDICAL CONDITIONS (E.G. CARDIAC DISORDERS)		USE OF MEDICATION / HERBS INDUCING PHOTOSENSITIVITY	
PREGNANCY AND NURSING		FACIAL LASER RESURFACING / DEEP CHEMICAL PEELING, LAST 3 MONTHS	
IMPAIRED IMMUNE SYSTEM		NEEDLE EPILATION, WAXING OR TWEEZING, LAST 6 WEEKS	
DISEASES STIMULATED BY LIGHT (E.G. LUPUS, PORPHYRIA, EPILEPSY)		TATTOO OR PERMANENT MAKEUP	
DISEASES STIMULATED BY HEAT (E.G. HERPES SIMPLEX)		TANNED SKIN	
ENDOCRINE DISORDERS (E.G. DIABETES, PCOS)		INJECTIONS/FILLERS	
SURGICAL PROCEDURES			
List any medications taken			
List any allergies			
Detail any medical condition			
Other considerations			

Morpheus8 Informed Consent

PATIENT NAME

____

TREATMENT SITES

____

I DULY AUTHORIZE Crystal's Skin & Beauty **TO PERFORM** Morpheus8 **TREATMENT.**

I understand that the device being used for Subdermal and dermal remodeling of facial and body areas through fractional coagulation and sub-necrotic bulk heating of which I am consenting to be a patient receiving Morpheus8 treatment.

I understand that clinical results may vary depending on individual factors, including but not limited to medical history, skin type, patient compliance with pre- and post-treatment instructions, and individual response to treatment.

I understand that there is a possibility of short-term effects such as reddening, mild burning, temporary bruising and temporary discoloration of the skin, as well as the possibility of rare side effects such as scarring and permanent discoloration. These effects have been fully explained to me ________ (patient's initials).

I understand that treatment with this system involves a series of treatments and the fee structure has been fully explained to me ________ (patient's initials).

I certify that I have been fully informed of the nature and purpose of the procedure, expected outcomes and possible complications, and I understand that no guarantee can be given as to the final result obtained. I am fully aware that my condition is of cosmetic concern and that the decision to proceed is based solely on my expressed desire to do so. I confirm that I have informed the staff regarding any current or past medical condition, disease or medication taken.

I consent to the taking of photographs and authorize their anonymous use for the purposes of medical audit, education and promotion.

I certify that I have been given the opportunity to ask questions and that I have read and fully understand the contents of this consent form.

Patient Signature____

Date____________________________________

Witness___________________________________