A&WMC
Morpheus 8 Treatment

Name:_____Date:_____
(First) (Last)

Date of Birth:_____Age:_____Weight:_____Height: _____

Home Address:_____

City:_____State:_____Zip:_____

Cell Phone:_____Occupation:_____

Email Address:_____

Fitzpatrick Skin Type: I II III IV V VI

Last prolonged exposure to Sun or tanning bed:_____

Ethnicity:_____

Use of Pacemaker/Defibrillator?: Yes ( ) No ( ) _____

Use of any metal implants?: Yes ( ) No ( ) If yes, specify:_____

History of Diabetes, PCOS, Lupus: Yes ( ) No ( ) If yes, specify:_____

History of Herpes: Yes ( ) No ( ) Last episode: _____

Any cardiac disorders?: Yes( ) No ( ) | If yes, specify:_____

Any history of bleeding?: Yes ( ) No( ) _____

Impaired immune system?: Yes ( ) No ( ) _____

Any skin disorders?: Yes ( ) No( ) | If yes, specify:_____

History of Keloids or Abnormal wound healing?: Yes ( ) No ( ) _____

Facial laser resurfacing/Deep chemical peeling?: Yes ( ) No ( ) When:_____

Injections/Fillers/Botox?: Yes ( ) No ( ) When:_____

Surgical procedures:_____

List of medications and vitamins: _____

Allergies:_____

Detail any other medical condition:_____

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MORPHEUS8 CONSENT FOR PROCEDURE

I give my informed and voluntary consent and authorize Dr. Angelica Hernandez and the staff of Adolescent & Women Medical Care to perform the Morpheus8 treatment. I understand that this procedure involves microneedling combined with radiofrequency technology to remodel and rejuvenate targeted facial and body areas.

I certify that I have been fully informed of the nature, purpose, expected benefits and possible complications of this procedure. I acknowledge that temporary side effects may include redness, mild burning, bruising and skin discoloration.

I understand that no specific outcome can be guaranteed, as outcomes may vary depending on individual response.

I confirm that I have disclosed all current and past medical conditions, illnesses, and medications to the medical staff.

I agree to have before and after photographs taken, and consent to the application of topical anesthetics as well as the optimal use of Pro-Nox (laughing gas) as part of this procedure.

I understand that smoking may reduce the effectiveness of this treatment due to the negative impact of toxins on the stem cells response.

I fully agree to release and hold harmless Adolescent & Women Medical Care, Dr. Angelica Hernandez and all affiliated parties, from any liability that may arise as a result of this treatment now and in the future.

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

Patient Name:_____

Signature:_____

Date:_____

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PRE-TREATMENT INSTRUCTIONS

・Avoid sun exposure for 10 to 14 days before and after the treatment.
・Discontinue retinol products 7 days prior to treatment.
・If you have a history of cold sores (Herpes), begin antiviral medication at least 1 day before treatment and continue for 3 days afterward.
・If you bruise easily, take oral Arnica or Silagen Arnica-Bromelain 1 day before treatment and continue for 3 days after.
・Avoid waxing, chemical peels, microdermabrasion, microblading 4 weeks prior to your appointment.
・Avoid Aspirin, Aleve, Motrin, drinking alcohol, smoking, or eating spicy foods for 3 days before and after treatment.
・If your skin type 4 to 6 (darker) or 1 to 5 with active tan, you must use a pigment control cream starting 10 days before treatment. Discontinue use 2 days before the procedure.
・If you have had any of the following treatments:
    *Botox, wait 1 week
    *Demal fillers, wait 3 months
    *Deep chemical peel, fractional laser or CO2, wait 3 months
    *Accutane, wait 6 months
・Men must arrive clean-shaven on the day of the procedure.
・For best results, a series of 3 treatments, spaced 4 weeks apart is typically recommended.

TREATMENT DAY

・Apply a thick layer of lidocaine (EMLA cream, sent to your pharmacy) to the area of treatment 1 hour before your appointment.
・Do not wear makeup on the day of the procedure.
・Notify the staff of any recent changes to your medical history, including the use of antibiotics or other medications.

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POST-TREATMENT INSTRUCTIONS

- Use a clean pillowcase the night of the treatment.
- Continue the antiviral and Arnica therapy.
- Avoid for 3 days: sexual activity, strenuous exercise (aerobics, cycling, weightlifting, running, yoga, Pilates), alcohol, and smoking.
- Do not apply any skin products on the day of the treatment, except for the post-treatment kit.
- Use it for 10 days. Reuse it for the next 2 treatments.
- Use sunscreen daily, SPF 30 or higher.
- You may apply makeup after 2 days; foundation can be used after 3 days, but if possible, wait 1 week.
- Restart Pigment Control Kit day 11.
- Bruising, redness, and swelling are normal and should subside gradually.
- Tiny scabs may appear after 1-3 days and last several days. Do not scratch, even if itchy. Let them shed naturally.
- Blisters are rare but if they occur, treated with a topical antibiotic.
- Avoid regular soaps, exfoliating products, retinol, and astringents for 2 weeks.
- Avoid sauna, hot tubs for 2 weeks.

PRECAUTIONS

- If you have a history of acne, melasma, rosacea, eczema or psoriasis.
- History of keloid formation, abnormal wound healing, very dry and fragile skin.
- History of bleeding, coagulopathies or use of blood thinners.
- History of skin cancer.
- Treating over tattoos or permanent makeup.

CONTRAINDICATIONS

- If you have a pacemaker or electronic implant in any part of the body.
- If cochlear implants in the ear.
- Permanent metal implants in the treated areas, unless in the periosteal plane.
- Pregnancy.
- Poorly control diabetes HBA1C > 8.
- Impaired immune system due to HIV, medications for organ transplant.