MICHELE MACLEAN, M.D.

Cosmetic Medicine Health History

Name _____ **DOB**_____

Address _____

Cell _____ **Home** _____ **MSI**_____ **Exp Date**_____

Email _____ **Emerg Contact Name/Phone** _____

Family Physician _____

Do you have:

□ Cold sores/herpes _____if so, do you have access to Antiviral Medication _____
□ Special event in the next 2 weeks _____
□ Active infection _____ Antibiotics _____
□ Fainting history _____
□ Needle phobia (tell us as we can help you) _____
□ Recent or planned dental work in a 2-4 week time span _____
□ Accutane in the past 6 months _____
□ Sinus/Rhinitis infection _____
□ Skin Disease /Keloid _____
□ Bleeding disorders _____
□ HIV or Hepatitis _____
□ Allergy to Yellow Jacket Bees _____
□ Eye issues including lid drop _____
□ Body Dysmorphic Disorder or OCD _____
□ Diabetes _____
□ Steroid Therapy _____
□ Autoimmune disorder (Lupus, RA, Thyroid) _____
□ Neurological - ALS, MS, Parkinson's Dz, Myasthenia Gravis, Seizures, Numbness, Muscle Weakness_____
□ Hypertension (High Blood Pressure not under control) _____

□ Hormonal imbalance/Therapy _____

□ Kidney Disease _____

□ Cancer/Chemo/Radiation _____

□ Orthopedic implants _____

□ Pacemaker/Defibrillator _____

□ Anything else you think relevant to your care _____

□ Previous surgeries Face/Neck/ Dental_____

□ List Prescription Meds _____

□ List OTC/Herbal Meds _____

□ Allergies _____Anaphylaxis (severe allergy)_____

□ Pregnant _____ Trying in the next 6 mos _____ Not sure _____

□ Breastfeeding _____

□ Prior Botulinum_____ Last tx ____ Satisfied? If not, why _____

□ Prior Filler _____ Where/When _____

Satisfied? _____

Please be accurate so we can keep you safe. Advise us if changes occur in your health. I acknowledge I read, understood and answered the medical history truthfully.

Patient Signature _____

MD Signature _____

RN Signature _____

I am interested in:
Botulinum Neuromodulator_____

Fillers _____

Hyperhydrosis (Excessive sweating) _____

Skin tags _____

Sun Spots _____

Age Spots _____

Skin Care Advice / Products _____

Michele MacLean MD | CCFP | AAFP
Tel 902-430-0990 | Fax 902-423-0990 (Call if the treated area becomes tender, red, swollen or itchy)

CONSENT FOR MICRONEEDLING

I hereby authorize Dr. Michele MacLean or Jenna Gallop RN, to perform Microneedling Therapy.

What to Expect:

The procedure is generally well-tolerated with mild prickling sensation. Topical anesthetic will be applied. Your skin will be pink/red like a sunburn with resolution expected by day 2-4, some patients heal completely in 24 hours. Minor bleeding and bruising is possible. Your skin may feel warm, tight, and itchy and should subside in 12-48 hours. Flaking may occur for several days. Results may vary and are not permanent as natural aging wiill occur. Remodeling takes months, and a series of sessions are usually needed.

Pre-procedure:

- **Avoid excessive sun 24 hours prior or having a sunburn the day of treatment**
- **Stop Retinols, AHA's 1-2 days prior, no Advil Motrin or Advil 3 days prior to aid controlled inflammation**
- **Avoid if active breakouts or open lesions are present**
- **Allow at least 24 hours after autoimmune therapies before treatment**
- **Wait 6 months after isotretinoin therapy (Accutane)**
- **Fitzpatrick 4-6 (darker skin tones) Pigment may darken before lightening**
- **Microneedling may cause flare of coldsores. Pretreatment with Valtrex 500mg every 12 hours for 2 days prior to the day of treatment s recommended. Delay treatment if you have a current breakout.**
- **Avoid self-tanners for 2 weeks prior and 3 days post-procedure**
- **Avoid Neurotoxins or Fillers, Lasers, Electrolysis, Waxing, Depilatories, facial surgery 2 weeks prior**

Contraindications: Mark yes or no

Allergy to anesthetics (ie lidocaine) or stainless steel _____
Irritated skin, open wounds, active skin cancer _____
Bleeding disorders _____
Pregnant or Nursing _____
Accutane use _____

Skin Pen has not been evaluated in:

Actinic Keratosis - Active Acne - Collagen Vascular Diseases such as Rheumatoid, Lupus, Anklyosing Spondyliitis, Sjogens - Diabetes - Temporal Arteritis - Ehlos Danlos -

Marfans - Osteogenesis Imperfecta - Eczema - Psoriais - Immunosuppression History of Contact Dermatitis - Raised moles in treatment area - Rosaeca - Active herpes or warts - Keloid Scars - Anticoagulants - Scars/Stretch Marks less than one year old - Sclerodema
Post Procedure:

Avoid retinols, Vit C for 3 days or til fully healed. Avoid waxing, lasers, and facial treatments for 2 weeks post-procedure.
Avoid strenuous exercise/excessive perspiration x 72 hrs (discomfort, irritation may occur)
SkinFuse Lift can be used for skin hydration up to 24 hours post-procedure
Avoid any sun exposure for 24 hours and minimize sun exposure for 72 hours. After 24 hours use SPF 30-50 daily

Client Signature and Date _____

MD Signature and Date _____

RN Signature and Date _____

4 -6 week Follow-Up Appointment Date _____

Consent to Use Electronic Communications

Michele MacLean, M.D.
drmml2001@gmail.com
902-430-0990
www.michelemacleanmd.com

Dr. MacLean has offered to communicate using the following means of electronic communication the services [check all that apply]:

Email _____

Text _____

Video conferencing (Webex, Teams) _____

Social media _____

Website _____

Client Acknowledge and Agreement:

I acknowledge that I have read and fully understand the risks, limitations, conditions of use, and instructions for use of the selected electronic communication.

I acknowledge and understand that despite recommendations that encryption software be used as a security mechanism for electronic communications, it is possible that communications with the Physician or the Physician's staff using the Services may not be encrypted. Despite this, I agree to communicate with the Physician or the Physician's staff using these Services with a full understanding of the risk.

I acknowledge that either I or Dr. MacLean may, at any time, withdraw the option of communicating electronically through the Services upon providing written notice. Any questions I had have been answered.

Name: _____

Address: _____

Phone: _____

Email _____

Client signature: _____ **Date:** _____

Witness signature: _____ **Date:** _____