

VSOFT LINE

JOURNAL FOR AESTHETICAL TREATMENTS WITH PDO THREADS

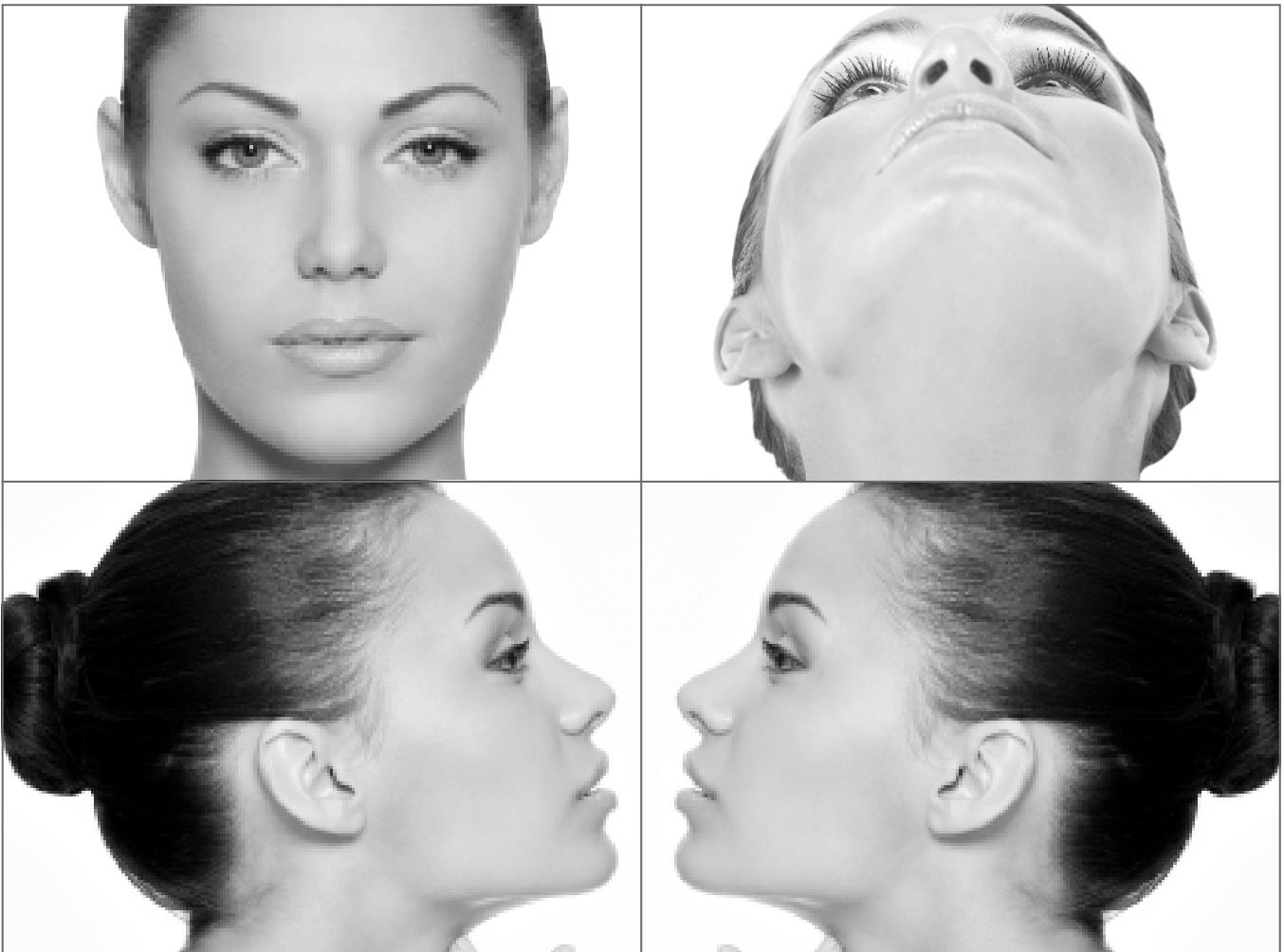
Name:
Address:
ID number:
Mobile number:
Practitioner:
Date:

Preparation	X = yes	Brand name / Product / Type	Number/ Volume
V Soft Line			
Dermal filler			
Botulinum Type A			
Mesotherapy			
Therapy			
Other:			

Lot/batch#

	LOT labels/stickers:

Notes



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Client	Treatment	X=yes	Client signature	Date
Name:	V Soft Line			
ID number:	Dermal filler			
Address:	Botulinum toxin type A			
ZIP code and city:	Mesotherapy			
Mobile number:	Other			
E-mail:				

Have you ever experienced any of the below listed symptoms?

Select all options that apply	Yes	No	If "yes", please specify	Notes
High blood pressure				
Diabetes				
Drug sensitivity/intolerance				
Allergy				
Heart- or lung disease (impaired breathability)				
Skin disease (e.g. keloid, perofal, dermetitis, psoriasis)				
Mental illness				
HIV infection or other blood borne infection				
Chronic inflammation (rheumatism)				
Have you ever had a dental anesthetic?				
Other disorders or indications not mentioned above (please specify below)				

Specify previous treatments	Yes	No	If "yes", please specify	Notes
V Soft Line				
Permanent Dermal Filler				
Botulinum toxin type A				
Mesotherapy				

If yes, please specify the brand of each preparation and the dates for treatment, respectively

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Contraindications	Yes	No	If "yes", please specify	Notes
Pacemaker				
Heart disease				
Active Acne				
Active Herpes / Shingles				
Are you pregnant or do you breastfeed?				

Affirmation	Yes	No	If "yes", please specify	Notes
I have understood all of the above questions and I am above 18 years old				

<p>INFORMED CONSENT / PATIENT CONSENT</p> <p>The practitioner who will perform the aesthetic treatment has provided all the information relating to potential benefits, limitations and alternative treatments. I fully understand its execution. All my questions and considerations have been answered to my satisfaction. I have also read and understood the accompanying informative material. I am well aware of all possible contraindications, unwanted effects and results.</p> <p>I accept the risks, side effects and possible complications that may arise from this treatment. There may be redness and swelling. I understand that results are not guaranteed. The duration of the results from the treatment may be shorter or longer than the specified time period.</p> <p>I have answered the questions about my medical history to the best of my ability. I certify that I have been informed about the treatment in accordance with the above and I agree to the treatment by signing this form.</p>	<p>GDPR</p> <p>I certify that I have read and approved the GDPR policy of my GP on the accompanying appendix, or on my GP's website.</p> <p>Signature _____ Place _____</p> <p>Printed name _____ Date _____</p> <p>.....</p> <p>.....</p>
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