



Aesthetic Wellness Medication Pre Consultation Form

Medical screening, compounded and peptide therapy assessment, and informed consent

Complete this form before your consultation. Your answers help the clinician evaluate safety and medical appropriateness. Completing or signing this form does not guarantee that treatment will be prescribed.

Patient Information

Full legal name

Date of birth

Phone

Email

Primary care clinician

Preferred pharmacy

Treatment Goals and Areas of Concern

- | | |
|---|--|
| ☐ Skin quality or texture | ☐ Pigmentation |
| ☐ Hair or scalp concerns | ☐ Body composition |
| ☐ Recovery or healthy aging | ☐ Energy or metabolic support |
| ☐ Inflammation or tissue support | ☐ Other |

Describe the concern, location, duration, prior evaluation, and products or procedures already tried

Medication Categories Being Discussed

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|--|---|
| ☐ Topical prescription medication | ☐ Oral prescription medication |
| ☐ Subcutaneous or intramuscular medication | ☐ Compounded vitamin or nutrient preparation |
| ☐ Compounded peptide based preparation | ☐ Growth hormone or IGF 1 pathway product |
| ☐ Copper peptide or skin related peptide product | ☐ Other |
| ☐ No preference; clinician recommendation requested | |

Medical and Aesthetic Safety Screening

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| ☐ Pregnant, trying to conceive, or breastfeeding | ☐ Current or prior cancer, tumor, suspicious lesion, or unexplained mass |
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|--|---|
| ☐ History of melanoma, skin cancer, or atypical moles | ☐ Autoimmune, connective tissue, or inflammatory disease |
| ☐ Diabetes, prediabetes, insulin resistance, or recurrent low blood sugar | ☐ Bleeding disorder or use of anticoagulant or antiplatelet medication |
| ☐ Heart disease, arrhythmia, edema, or uncontrolled blood pressure | ☐ Kidney or liver disease |
| ☐ Severe allergy, anaphylaxis, or reaction to an injectable or topical product | ☐ Keloid or hypertrophic scarring |
| ☐ Active rash, acne flare, open wound, cold sore, infection, or impaired immunity | ☐ Neuropathy, altered sensation, or poor circulation |
| ☐ Recent surgery, laser, peel, injectable, device treatment, or planned procedure | ☐ Current isotretinoin or other medication affecting skin healing |
| ☐ Use of growth hormone, IGF 1 therapy, insulin, immunosuppressant, or cancer therapy | ☐ Product obtained from an online, grey market, or nonlicensed source |

Explain every item checked above

List all prescriptions, compounded products, supplements, allergies, and prior aesthetic reactions

Recent Information Available

The clinician will determine what is relevant to the proposed medication and the patient's history. Upload available results or records.

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|---|--|
| ☐ Current medication list | ☐ Current photographs for clinical comparison |
| ☐ CBC | ☐ CMP or kidney and liver tests |
| ☐ A1c or fasting glucose | ☐ Pregnancy test if applicable |
| ☐ Dermatology or pathology records | ☐ Cancer screening information |
| ☐ Prior treatment records | ☐ No recent results |

Patient Specific Compounding Assessment

The prescriber must independently document the clinical reason for any compounded preparation. Patient preference alone does not establish medical necessity.

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| ☐ Documented allergy or intolerance to an inactive ingredient | ☐ Clinically necessary strength not commercially available |
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- | | |
|---|---|
| ☐ Clinically necessary dosage form not commercially available | ☐ Clinically necessary combination determined after evaluation |
| ☐ FDA approved option is not medically appropriate for a documented reason | ☐ No patient specific reason identified |
| ☐ Other | |

Describe the exact product tried, response, adverse effect, ingredient issue, dosage form need, or other clinical difference

Risks and Informed Consent

Patient Acknowledgment and Consent

Please initial each statement in Vagaro or select each required acknowledgment before signing.

- ☐ I understand an aesthetic or wellness goal does not guarantee that a medication is medically appropriate. The clinician may recommend another evaluation, an FDA approved option, dermatology or other specialist care, nonmedication treatment, or no treatment.
- ☐ Possible local effects include pain, burning, redness, swelling, itching, bruising, bleeding, infection, delayed healing, acne or rash, pigment change, hair or skin texture change, scarring, keloid formation, numbness, tenderness, and an unsatisfactory or asymmetric cosmetic result.
- ☐ Possible systemic effects vary by product and may include headache, dizziness, nausea, fatigue, allergic reaction, fluid retention, blood pressure or heart rate change, glucose change, hormone or laboratory abnormality, drug interaction, and an unexpected or currently unknown effect.
- ☐ Peptide based or growth pathway products may have limited human evidence and unknown long term effects. Potential concerns include immune reactions, peptide related impurities, degradation or aggregation, tissue growth effects, fluid retention, joint or nerve symptoms, and altered glucose regulation. They may be inappropriate with active malignancy or other conditions identified by the clinician.
- ☐ I understand compounded drugs are not FDA approved and FDA does not review them before marketing for safety, effectiveness, quality, strength, or purity. Compounded or injectable products may also present risks from contamination, potency variation, storage problems, dosing error, or incorrect administration.
- ☐ I will use only the product prescribed for me and obtained from the approved pharmacy, will follow storage and administration instructions, will not share medication, and will not combine it with an online or grey market product.
- ☐ I will stop use and contact the clinical team for a significant reaction. I will seek urgent or emergency care for trouble breathing, facial or throat swelling, fainting, chest pain, a new neurologic symptom, rapidly spreading redness, severe pain, high fever, persistent vomiting, severe abdominal pain, or another potentially serious reaction.
- ☐ I understand results vary and are not guaranteed. Photographs may be recommended for clinical documentation but will not be used for marketing without a separate written authorization.



Signatures

By signing, I confirm that I have read this form, answered truthfully, had an opportunity to ask questions, and voluntarily consent to the evaluation and any treatment specifically ordered after consultation. I may decline or withdraw consent before treatment. I understand that this acknowledgment does not waive rights that cannot legally be waived or excuse negligent or unlawful conduct.

Patient full legal name

Date of birth

Patient signature

Date and time

If signed by a legally authorized representative:

Representative name

Relationship or authority

Representative signature

Date and time

Clinician Use Only

☐ Consultation completed in person

☐ Consultation completed by telehealth

☐ Identity verified

☐ Medication reconciliation completed

Blood pressure

Heart rate

Weight

BMI

Pertinent history, examination, and assessment

Diagnosis or treatment indication

☐ Not a candidate

☐ Additional records or testing required

☐ Candidate after shared decision-making

☐ Referred for additional evaluation

Patient-specific medical necessity and rationale for any compounded preparation

Selected medication, formulation, dose, monitoring plan, and follow-up

I independently reviewed the information above, completed an appropriate clinical evaluation, discussed material risks, benefits, alternatives, and uncertainties, and determined whether aesthetic wellness medication therapy is medically appropriate. The patient form alone was not used as a substitute for clinical judgment.

Clinician name and credentials _____ Clinician signature _____ Date and time _____