REGENERATION, P.C.

VOTIVA(FRACTORA V/FORMA V) INTAKE FORM

Patient Name_____ Date of Birth_____
Address_____ City_____ State_____ Zip code _____
Home phone_____ Cell Phone_____

Gynecological History
Last Pap Smear: _____ Normal ☐ Abnormal ☐ History of abnormal Pap? Yes ☐ No ☐
Last Menstrual Period _____
Are you currently pregnant? Yes ☐ No ☐ Are you currently Breastfeeding Yes ☐ No ☐
Any vaginal or Pelvic area surgery in the last 12 months? Yes ☐ No ☐

Medical History
Please list past surgical history: _____
Current medications: _____
Allergies: _____

Have you ever been diagnosed with any of the following?

Diabetes?	Yes ☐ No ☐	Autoimmune disease?	Yes ☐ No☐
Cardiac disease?	Yes ☐ No ☐	History of cancer?	Yes ☐ No☐
Type II herpes?	Yes ☐ No☐	Type I herpes?	Yes ☐ No☐
HIV?	Yes ☐ No ☐	AIDS?	Yes☐ No ☐
Melanoma?	Yes ☐ No ☐	Bleeding disorders	Yes ☐ No ☐

Do you currently have any of the following?

Active malignancy	Yes ☐ No ☐
Metal implants or mesh implants:	Yes ☐ No ☐
Any active electrical implant in any region of the body:	Yes ☐ No ☐
Current UTI:	Yes ☐ No ☐
Current Pelvic infection:	Yes ☐ No ☐
Current pelvic tract infection	Yes ☐ No ☐
Abnormal moles in the treatment area:	Yes ☐ No ☐
Tattoo or permanent make-up in the treatment area:	Yes ☐ No ☐
Excessively tanned skin in the treatment area:	Yes ☐ No ☐
IUD:	Yes ☐ No ☐

Active conditions in the treatment area such as:

Open laceration:	Yes ☐ No ☐	Psoriasis:	Yes ☐ No ☐	Abrasion:	Yes ☐ No ☐
Lesions:	Yes ☐ No ☐	Eczema:	Yes ☐ No ☐	Rash:	Yes ☐ No ☐

Have you ever had or been told you had any of the following?

Uterine prolapse	Yes ☐ No ☐
Cystocele	Yes ☐ No ☐
Rectocele	Yes ☐ No ☐
Pelvic lymph node dissection:	Yes ☐ No ☐
Poor lymphatic drainage:	Yes ☐ No ☐
Epidermal or dermal disorder involving collagen or microvasculature:	Yes ☐ No ☐
Disease which may be stimulated by radiofrequency:	Yes ☐ No ☐
History of skin disorder:	Yes ☐ No ☐
History of keloid scarring:	Yes ☐ No ☐
Abnormal wound healing:	Yes ☐ No ☐

Have you taken any of these medications in the last 6 months?

Immunosuppresive medications:	Yes ☐ No ☐
Corticosteroids:	Yes ☐ No ☐
Accutane:	Yes ☐ No ☐
Anticoagulants:	Yes ☐ No ☐
Cancer treatment in the last 5 years:	Yes ☐ No ☐

Do you have any other significant health concern or possible contraindication the provider should know about prior to your procedure? _____
_____
_____
_____

REGENERATION, P.C.

VOTIVA CONSENT FOR FORMA V/FRACTORA V

I understand that the Votiva Forma V and Fractora V use radiofrequency (RF) for remodeling of vaginal tissue. It has been explained to me that although RF treatments for vaginal rejuvenation conditions have been very effective there is not guarantee that I will benefit from this treatment. I understand the most common side effects and complications from this procedure are as follows:

1. Pain: You may experience pain during of after the procedure. If you feel significant pain after the procedure, you may use over the counter pain medications.
2. Swelling: There may be swelling in the treatment area immediately after the treatment and generally for one week after the procedure.
3. Bruising: You may experience temporary bruising in the treated area, which will subside with adequate time.
4. Ecchymosis and Purpura: You may experience some temporary bruising or purple discoloration in the treatment area, which will subside with adequate healing time.
5. Blistering/Bullae: You may experience some temporary blistering in the treatment area, which will subside with adequate healing time.
6. Burn: You may experience a burn, which can be mild, moderate or severe to different degrees in the treatment areas. Minor burns generally heal without difficulty but more severe burns, though rare, can lead to scarring, sensory or pigmentary changes.
7. Pigmentary changes: You may experience lightening of the skin, which may be temporary or permanent (hypopigmentation). You may also experience temporary or permanent darkening of the skin (hyperpigmentation).
8. Scarring- The risk of this complication is minimal, but it can occur whenever the surface of the skin is disrupted. Strict adherence to all post-procedure instructions will minimize the possibility of this occurring.
9. Allergic reactions: It is possible to experience an allergic reaction to the topical anesthetic or to the procedure equipment used.
10. Herpes Eruption: It is possible, even with antiviral prophylaxis, to experience a herpes eruption if you are a HSV carrier. Inform you provider immediately if you experience pain, skin eruptions, or blistering post-treatment so that the proper treatment can be started.
11. Infection: This treatment has the potential to cause skin infection due to the disruption in the skin barrier. Infection is unlikely, but can be life threatening if it does occur and is left untreated; signs and symptoms of infections include: redness, fever, pain, pus, and swelling. Should an infection occur, you should contact your provider for immediate evaluation and treatment.

It is important that you communicate with your provider should you experience any of the listed side effects or complications.

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

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 it is my decision to proceed and is based solely on my desire to do so.

I confirm that I have informed the staff regarding any current or past medical condition, disease or medication being taken. I confirm that I have had an up to date, normal vaginal exam and PAP test and have communicated these results with my provider.

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'S ACCEPTANCE OF RISKS

I have read the above information in its entirety and have discussed the risks and benefits of Votiva vaginal treatment with my provider. I understand the information provided. No guarantees about results have been made. I understand that additional treatments may be necessary, for which Regeneration, P.C. will charge an additional fee. I hereby assume all risks, hazards and costs of care or expense associated with or which may arise from such treatment, hereby releasing the personnel and consultants and any sponsoring health care facility or institution and its affiliates and all of their agents and employees from any liability from said treatment except where such risks and hazards are the proximate result of gross negligence. By signing below, I agree that my provider has answered all of my questions and that I understand and accept the risks, benefits, and alternatives of **Votiva Forma V and Fractora V.**

_____ _____

Patient signature **Date**

_____ _____

Witness signature **Date**