A&WMC

# O-SHOT TREATMENT

Name:_____Date:_____
(First) (Last)

Date of Birth:_____Age:_____Weight:_____Occupation:_____

Home Address:_____

City:_____State:_____Zip:_____

Cell Phone:_____Alternative Phone:_____

Email Address:_____

**Gynecological History**

Last PAP (normal/abnormal)?:_____

If abnormal, specify and any treatment (Colpo, LEEP):_____

Last menstrual period?:_____

**Medical History**

Any diseases stimulated by heat?(ex: Herpes, Simplex): Yes( ) | No( ):_____

Any skin disorders?: Yes( ) | No( ):_____

Surgical procedures:_____

List of medications:_____

Allergies:_____

Detail any other medical condition:_____

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**O-SHOT CONSENT FOR PROCEDURE**

I give my informed and voluntary consent and I authorize Dr. Angelica Hernandez and staff of Adolescents & Women Medical Care to administer the O-Shot treatment.

I understand the proposed procedure is the injection of platelet-rich plasma to the vaginal submucosal and clitoral area,  named the O-Shot.

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 confirm that I have informed the staff regarding any current or past medical condition, disease or medication taken.

I consent to the administration of topical anesthetics.

Smokers have less positive response to this treatment than non-smokers, since the toxins in cigarette smoke block the response of the stem cells. There may be some variation in achieving the results requested as everyone's body type is different and may have a different response.

I fully agree to hold Adolescent & Women Medical Care, Dr. Angelica Hernandez and any and all parties affiliated with her, harmless and free from any liability that may arise as a result of this treatment both 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:_____