DIVINE PRO **Anamnesis and customer confirmation**

Customer confirmation / Anamnesis

Some diseases or the use of medication could cause negative consequences through the application of Divine Pro-technologies. In your own interest, we therefore ask you to answer the questions listed below honestly and truthfully.

Do you suffer from the following symptoms or diseases:

- Chronic skin diseases like herpes, psoriasis, eczema, acne
- Allergies or allergic reactions like slight redness, rashes, nausea, vomiting, diarrhea
- Blood clotting problems (taking blood thinners, thrombosis, danger of embolism)
- Disease of the endocrinological glands (e.g. diabetes)
- Cardiovascular diseases (high blood pressure)
- Immune diseases (reduced immune defence)
- Infectious diseases
- Nervous diseases (e.g. epilepsy)
- Are you on hormone therapy
- Dermographism

☐ No ☐ Yes (if yes, we ask you for a written consent of your doctor)

Are you currently taking or have you taken any medication last week (excluding contraceptives)?

☐ No ☐ Yes, which: _____

Do you have a pacemaker, an implant (also lifting threads) or a prosthesis?

☐ No ☐ If yes, in which region of the body? _____

Have skin injections (Botox, Hyaluron) or aesthetic surgery been performed?

☐ No ☐ If yes in which area and what kind of _____

Do you often sunbathe, go to a solarium or use self-tanning products (external or internal)?

☐ No ☐ If yes, when was the last time _____

Do you have permanent Make-up or Tattoos?

☐ No ☐ If Yes, in which area of the body? _____

Do you have pigment disorders?

☐ No ☐ If yes, which and where _____

Do you pursue a treatment that should make your skin softer, thinner (e.g. fruit acid application or microdermabrasion)? Or do you take medication against acne?

☐ No ☐ If yes, what treatment, products _____

Do you have allergic reactions to certain ingredients in cosmetics?

☐ No ☐ If yes, which _____

Are you pregnant?

☐ No ☐ Yes

I confirm that I have answered the questions honestly and accurately. If there are any changes from one treatment to another, I will inform you in advance without being asked.

Family name: _____ First name: _____ Date of birth: _____

Of course, these informations will be treated strictly confidential.
They serve only to secure the treatment.

Date and Signature: