GENEVEVE™

Patient Evaluation Form

Name:_____

IDEAL CANDIDATE (please indicate if you agree with the statements below)	**YES**	**NO**
I am experiencing symptoms of laxity		
Gynecological exam within last 3 years was normal		
I have active STD lesions		
I have prolapse beyond the hymenal ring		
I am menstruating at the time of procedure		
I am undergoing chemo/radiation therapy within previous 9 months		
I am breastfeeding, or have breast-fed within the last 6 months		
I have a thin recto-vaginal septum (<1 cm between vaginal and anal opening)		
I have chronic vulvar pain or vulvar dystrophy		
I have a large metal implant		
I have implanted mesh or pelvic sling prior to surgery		
OTHER CONSIDERATIONS		
I have medical conditions/medications that may interfere with the healing process (e.g., chronic use of anti-inflammatory drugs)		
I am willing to abstain from intercourse/tampon use as directed		
CONTRAINDICATED FOR TREATMENT		
I am currently pregnant		
I have an impacted Pacemaker or AICD (automatic implantable cardioverter-defibrillator)		

Patient Signature:_____ **Date:**_____

Aesthetic Center
OF SANTA CLARITA, INC.