MEDICAL HISTORY FORM

Last Name: ______________________ First Name: ______________________

Address: ____

City: ______________ State: __________ Zip Code: ____________

Telephone: Home: __________ Work: __________ Cell: ____________

Date of Birth: ______________ Sex: Female _____ Male _____

Family Doctor: ______________________ Phone: ______________

Pharmacy: ______________________ Phone: ______________

Emergency Contact: ______________________ Phone: ______________

Which body area/areas or condition would you like treated? ______________

____

____

Please answer all of the following questions **YES NO**

1. Do you have **ANY** current or chronic medical illnesses? ○ ○

Disclose any history of heat urticaria, diabetes, autoimmune disorders or any immunosuppression, blood disorders, cancer, bacterial or viral infections, medical conditions that significantly compromise the healing response, skin photosensitivity disorders, or <u>any</u> other condition or illness.

Please List: ____

____

2. Do you have **ANY** current or chronic skin conditions? ○ ○

Also disclose any history of vitiligo, eczema, melasma, psoriasis, allergic dermatitis, any diseases affecting collagen including Ehlers-Danlos syndrome, scleroderma, skin cancer, or <u>any</u> other skin condition.

Please List: ____

____

3. Are you currently under a doctor's care? If so, for what reason? ○ ○

____

4. Do you take/use **ANY** medications (prescriptions and nonprescriptions), vitamins, herbal or natural supplements, on a regular or daily basis? ○ ○

Please List: ____

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5. Are there any topical products (both medical and non-medical) that you use on your skin on a regular or daily basis? ○ ○

Please List: ____

6. Do you take/use ANY systemic/oral steroids (e.g., prednisone, dexamethasone)? ○ ○
7. Do you have **ANY** allergies to medications, foods, latex or other substances? ○ ○

    Please List: ____

8. (For women) are you or could you be pregnant? ○ ○
9. (For women) are menstrual periods irregular, or have you ever been diagnosed with Polycystic Ovarian Disorder? ○ ○
10. Do you have a history of herpes I or II in the area to be treated? ○ ○
11. Do you have a history of keloid scarring or hypertrophic scar formation? ○ ○
12. Do you have a history of light induced seizures? ○ ○
13. Do you have any open sores or lesions? ○ ○
14. Do you have any history of radiation therapy in the area to be treated? ○ ○

MEDICAL HISTORY, CONTINUED | | YES | NO

	YES	NO
15. In the last six (6) months, have you used any of the following: anticoagulants or blood-thinning medications; photosensitizing medications; or anti-inflammatory or blood thinning medications? Please List product name and date last used: ____________	O	O
16. In the last three (3) months, have you used any of the following products: glycolic acid or other alphahydroxy or betahydroxy acid products; exfoliating or resurfacing products or treatments? Please List product name and date last used: ____________	O	O
17. Do you have or have you ever had any permanent make-up, tattoos, implants, or fillers,including, but not limited to, collagen, autologous fat, Restylane®, etc.? If yes, please list locations on or in the body and dates: ____________	O	O
18. Do you have or have you ever had any Botulinums, such as Botox® or Dysport®? If yes, please list locations on or in the body and dates: ____________	O	O
19. Have you taken Accutane® (or products containing isotretinoin) in the last 12 months?	O	O
20. Have you taken Tretinoin (like Retin-A, Renova) in the last 6 months?	O	O
21. Have you had any unprotected sun exposure, used tanning creams (including sunless tanning lotions) or tanning beds or lamps in the last 4-6 weeks?	O	O
22. Do you have a pacemaker?	O	O

Please include your email address to receive appointment confirmations, and monthly information on special pricing and/or special events:

____________________@____________________

How did you hear about us? ____________________

Signature: ____________________ Date: ____________

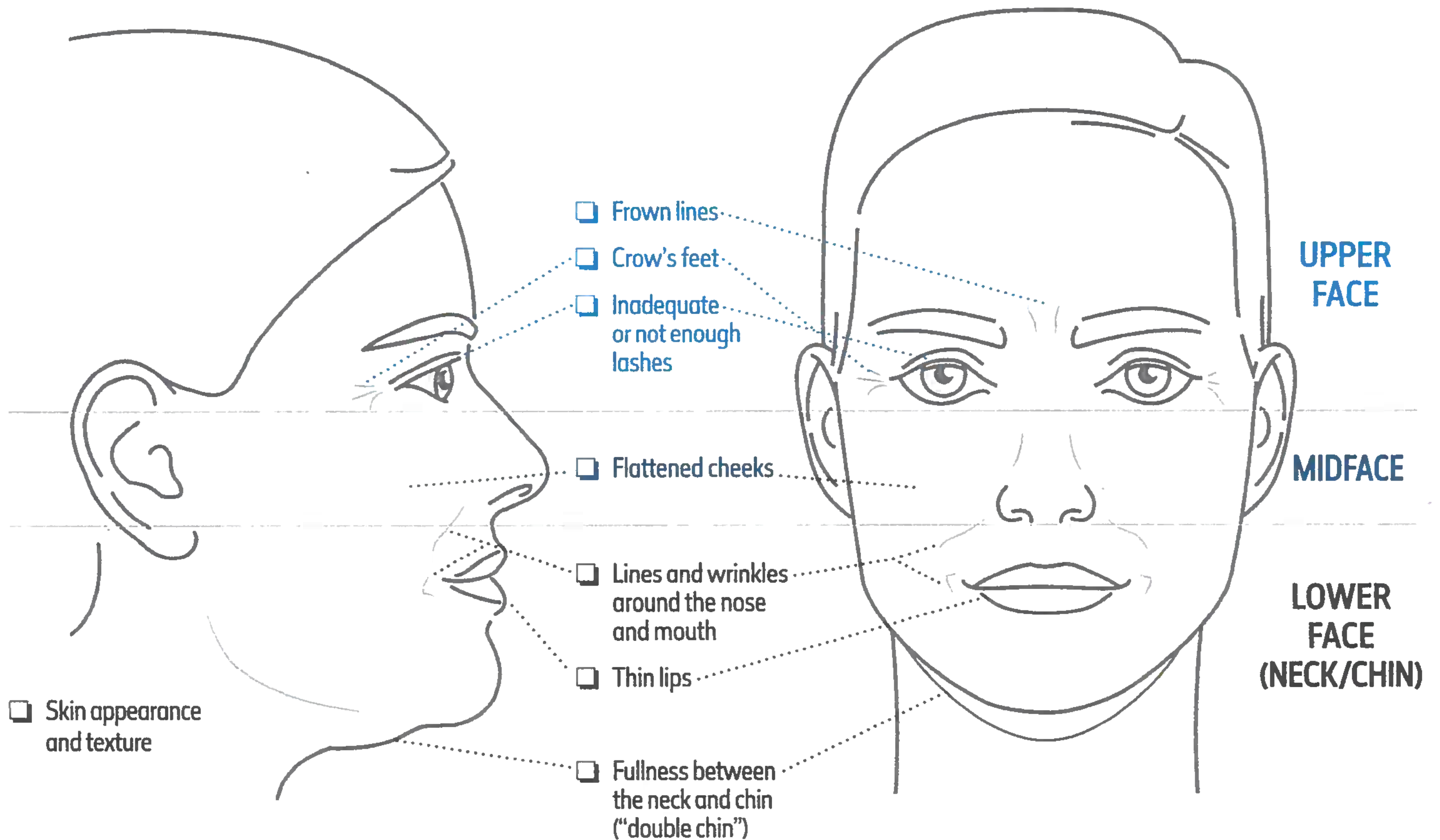
SELF-ASSESSMENT

NAME: ______________________ DATE OF BIRTH: ______________ DATE: ______________

What brings you in today? ______________________________

Select which areas of the face concern you on the diagram below.

By sharing how you see yourself, we can best evaluate your aesthetic goals and select an appropriate treatment for you.



Please complete and return this form to the front office before your consultation.

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CONSENT TO BOTULINUM TOXIN "A" TREATMENT

Botulinum Toxin a neurotoxin produced by the bacterium Clostridium A, can relax the muscles on areas of the face which cause wrinkles associated with facial expressions. Botulinum toxin treatments (Botox®, Xeomin & Dysport) can cause our facial expression lines or winkles to essentially disappear. Areas most frequently treated are: a) glabellar area of frown lines, located between the eyes; b) crow's feet (lateral areas of the eyes); and c) forehead wrinkles. Botox®, Xeomin & Dysport is diluted to a very controlled solution and when injected into the muscles with a very thin needle, it is almost painless. Clients may feel a slight burning sensation while the solution is being injected. The procedure takes about 15-20 minutes and the results last 3-5 months. With repeated treatments, the results may tend to last longer.

RISKS AND COMPLICATIONS

It has been explained to me that there are certain inherent and potential risks and side effects in any invasive procedure ad in this specific instance such risks include but are not limited to: 1) Post treatment discomfort, swelling, redness and bruising, 2) Post treatment bacterial, viral and/or fungal infection requiring further treatments, 3) Allergic reaction, 4) Minor temporary droop of eyelid(s) in approximately 2% of injections, this usually lasts 2-3 weeks, 5) Occasional numbness of the forehead lasting up to 2-3 weeks, 6) Transient headache, and 7) Flu-like symptoms may occur.

PHOTOGRAPHS

I authorize the taking of clinical photographs and their use for scientific purposes both in publications ad presentations. I understand my identity will be protected.

PREGNANCY, ALLERGIES & NEUROLOGIC DISEASE

I am not aware that I am pregnant, have any significant Neurological disease, or have any allergies to the toxin ingredients or to human albumin.

PAYMENT

I understand that this procedure is cosmetic and that payment is my responsibility.

RESULTS

I am aware that when small amounts of purified botulinum toxins are injected into a muscle it causes weakness or paralysis of the muscle. This appears in 3-10 days and usually last 3-5 months but can be shorter or longer. In a very small number of individuals, the injection does not work as satisfactorily or for as long as usual. I understand that I will not be able to "frown" while the injection is effective but that this will reverse after a period of months at which time retreatment is appropriate. I understand that I must stay in the erect posture and that I must not manipulate the area of the injection for the four hours post-injection period.

CONSENT TO BOTULINUM TOXIN "A" TREATMENT

I hereby voluntarily consent to treatment of Botulinum Toxin injections for the condition known as: Facial Dynamic Wrinkles. The procedure has been explained to me. I have read the above and understand it. My questions have been answered satisfactorily. I accept the risks and complications of the procedure.

____ ________________

Client Signature **Date**

____ ________________

Witness Signature **Date**