

**PATIENT INFORMATION AND MEDICAL HISTORY**

Name \_\_\_\_\_ Date \_\_\_\_\_  
 Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ E-mail Address \_\_\_\_\_  
 Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ Sex \_\_\_\_\_

**HISTORY**

**Please check if you have or have had –**

Diabetes _____	Irregular menses _____
Hepatitis _____	Heart problems _____
Herpes _____	Hysterectomy _____
Menopause _____	Hypertension _____
Sensitive to anesthetic _____	Photosensitive Disorder _____
Lupus _____	Autoimmune illness _____

Are you under the care of a physician? \_\_\_\_\_  
 Current/Recent medications \_\_\_\_\_

			<b><u>IF YES, EXPLAIN</u></b>
Keloid scars	Yes	No	_____
Hives	Yes	No	_____
Skin Cancer	Yes	No	_____
Waxing	Yes	No	_____
Electrolysis	Yes	No	_____
Cold Sores	Yes	No	_____
Hypersensitivity to skin products	Yes	No	_____
Skin Infections	Yes	No	_____
Tanning within the last 6 wks	Yes	No	_____
Use of acne products/drugs	Yes	No	_____
Laser skin resurfacing	Yes	No	_____
Chemical Peels	Yes	No	_____
Photo sensitizing substances	Yes	No	_____
Laser work of any type	Yes	No	_____

Medical Illness \_\_\_\_\_  
 Are you pregnant? \_\_\_\_\_  
 Allergies of any kind including drugs \_\_\_\_\_  
 Areas of interest for aesthetic treatment \_\_\_\_\_  
 Type of treatment requested Botox/ Filler \_\_\_\_\_

**I ATTEST THE ABOVE INFORMATION TO BE TRUE, KNOWING MY PROVIDER RELIES ON THIS INFORMATION TO PROVIDE SAFE AND EFFECTIVE TREATMENT.**

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

# **INFORMED CONSENT FOR BOTULINUM TOXIN INJECTION (BOTULINUM TOXIN TYPE-A AS BOTOX FROM ALERGAN)**

FOR THE TEMPORARY TREATMENT OF SUPERFICIAL FACIAL WRINKLES

Please initial after each statement and sign at the bottom.

Botox is the botulinum toxin and works by paralyzing nerves and muscles.

1. I, \_\_\_\_\_, consent to and authorize \_\_\_\_\_ to perform a treatment of facial wrinkles with Botox. \_\_\_\_\_
2. The nature and purpose of the treatment has been explained to me and questions I have regarding the treatment have been answered to my satisfaction. \_\_\_\_\_
3. I understand surgery or other treatment alternatives may be as effective or more effective in reducing the appearance of wrinkles. \_\_\_\_\_
4. I am fully aware of the risks of complications or injuries that can occur from this treatment, both from known and unknown causes, and I freely assume those risks. \_\_\_\_\_

The known complications could include:

- Redness, swelling/edema, itching, pain or pressure lasting more than one week
- Nodules or induration at the injection site
- Discoloration of the injection site
- Poor effect
- Allergic reactions
- The effects of Botox are apparent 2-5 days after treatment
- The effects usually last 4-6 months. Periodic retreatment will be necessary to maintain the effects of Botox
- Repeated treatment may lead to permanent loss of muscle tone in the treated area
- Bruising
- Facial asymmetry
- Paralysis leading to droopy eyelid and double vision
- Some patients may experience weakness or flu-like symptoms

- Some patients may develop antibodies to Botox

5. I also certify that I have none of the known conditions that would contraindicate treatment. These conditions include hypertrophy scars, a history of any autoimmune disease, or immune therapy. I am not pregnant, breast-feeding, and I have no known allergy to Botox. \_\_\_\_\_

6. I certify that I have read this entire informed consent and that I understand and agree to the information stated in this form. I certify that I am a competent adult of at least 18 years of age, or that if I am a minor under the age of 18, I understand that the consent of my parent/legal guardian will also be required before treatment. This informed consent is freely and voluntarily executed and shall be binding upon my spouse, relatives, legal representatives, heirs, administrators, successors, and assigns. I agree that any picture taken of my treatment site may be used for publication and teaching purposes, however, my name will not be disclosed and complete confidentiality of my name will be maintained. \_\_\_\_\_

7. No guarantee, warranty or assurance has been made as to the treatment results  
\_\_\_\_\_

8. I understand that the results are of temporary nature, and more treatments will be needed to maintain improvement. I agree to adhere to all safety precautions described here including: \_\_\_\_\_

- No laying down or reclining for four hours after injection
- No scratching or rubbing the injected area
- No bending forward for four hours
- Make up should be avoided for one to two hours after injection

9. I agree to pay \_\_\_\_\_ for the above mentioned services. \_\_\_\_\_

Patient Name (please print) \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_

Witness Signature \_\_\_\_\_ Date \_\_\_\_\_