BOTOX/DYSPORT and DERMAL FILLER Form

Client Information and Medical History

In order to provide you with the most appropriate skin care treatment, we would appreciate your time in completing the following questionnaire. All information is strictly confidential.

PERSONAL HISTORY

Client Name _____ Today's Date_____

Date of Birth _____/____/_____ Age _____ Gender ☐ M ☐ F Current Time_____am/pm

Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Other _____

Occupation _____

Home Address _____

City_____ State _____ Zip Code _____

Home Phone (_____) _____Work Phone (_____) _____ ext._____

Cell Phone (_____) _____ Email _____

Emergency Contact Name _____ Phone (_____) _____

Driver's License Number _____

How were you referred to **or** heard of us? _____

_____

Preferred Practitioner: ☐ Female Nurse ☐ Male Nurse ☐ **No preference**, whichever is available based on my requested appointment time.

MEDICAL HISTORY

1. Are you currently under the care of a physician? ☐ Yes ☐ No

2. Are you currently under the care of a dermatologist? ☐ Yes ☐ No

3. Do you have any of the following medical conditions? (Please check all that apply)

☐ **NONE**
☐ Cancer
☐ Diabetes
☐ High blood pressure
☐ Herpes
☐ Arthritis
☐ Frequent cold sores
☐ HIV/AIDS
☐ Keloid scarring
☐ Skin disease / Skin lesion
☐ Seizure disorder
☐ Hepatitis
☐ Hormone imbalance
☐ Thyroid imbalance
☐ Blood clotting abnormalities
☐ Any active infection

4. Do you have any other health problems or medical conditions? Please list:

☐ **NONE**
1. _____
2. _____
3. _____
4. _____
5. _____

5. What **oral medications** are you presently taking?

☐ Names (please list): _____
_____
_____

6. What **topical medications** or **creams** are you currently using?

☐ Names (please list):
1. _____
2. _____
3. _____

Question 7-9: Females Only

7. Are you pregnant or trying to become pregnant? ☐ Yes ☐ No
8. Are you using contraception? ☐ Yes ☐ No

9. Are you breastfeeding? ☐ Yes ☐ No

Allergies

10. Have you ever had an allergic reaction to any of the following?
(Please check all that apply and describe the reaction you experienced.)

☐ **NONE**
☐ Food
☐ Latex
☐ Cosmetics
☐ Aspirin
☐ Lidocaine
☐ Hydrocortisone
☐ Hydroquinone or skin bleaching agents
☐ Others: _____

Cancellation policy

Cancellation is required 24 hours prior to appointment; failure to cancel within the required time will result in a fee of $35.00 being charged to the credit card on file. A No Show is considered failure to cancel or failure to show for a scheduled appointment, a fee of $50.00 will be applied to the credit card on file.

I attest this information to be true, knowing my technician relies on this for safe and effective treatment; I understand the cancellation policy and agree to its terms.

I certify that the preceding medical, personal and skin history statements are true and correct. I am aware that it is my responsibility to inform the technician, esthetician, therapist, doctor or nurse of my current medical or health conditions and to update this history as a current medical history is essential for the caregiver to execute appropriate treatment procedures.

Signature_____ Date _____

BOTOX/DYSPORT CONSENT FORM

Touch of Class Medspa & Laser Center | (818) 502-3636 | Fax: (818) 245-8436

Botox or Dysport therapy for wrinkles is an injection treatment designed to reduce facial expression lines. They are both approved by the FDA for the treatment of wrinkles in the glabellar area. When this therapy is performed, small amounts of toxin are injected into the facial muscles responsible for movement associated with lines and wrinkles. This injection weakens or paralyzes the muscle, thus reducing the associated lines and wrinkles. The most common areas for this therapy are the lines between the eyes, forehead wrinkles, crow's feet and on occasion around the mouth. This therapy is temporary, meaning it has to be repeated on a regular basis to remain effective. The weakening effect **gradually begins anywhere from 24 hours to 3 days, and is sometimes not complete for two weeks.** During this period, you may notice asymmetry, or unevenness, within treated areas. This asymmetry will usually correct itself as the toxin takes effect. For maximal results it is recommended that you maintain an upright posture for at least 4 hours. During this time it is also recommended that the treated area not be rubbed vigorously or massaged. You may wish to actively move, by expression, the treated areas during this time, as this may help to increase the response of the targeted muscles.

There are no known permanent side effects. There are, however, several possible **side effects** that are temporary, which include:

Bruising: Occurs at or near the injection site. This effect clears within 7-10 days. No treatment is necessary.

Headache: Related to the actual injections, is usually mild and transient, lasting less than 24 hours. May be relieved with Tylenol.

Asymmetry: As described above, if present, will be noticed in the first two weeks of therapy. May be corrected with "touch-up" injections if necessary. There is a fee for touch-up injections.

Numbness: A change in sensation noticed by some patients in the treated areas, better described as "dullness", it is usually only noticed for a few days after treatment.

Eyebrow or eyelid ptosis (drooping) or diplopia (double vision): Seen 1-2% of patients receiving this therapy, is temporary, lasting weeks and usually mild.

Also for reasons not fully understood, some patients may be less sensitive or "resistant" to the effects of the toxins. Very deep creases may not be completely resolved with treatment.
If you are pregnant or nursing, these are not recommended.

I authorize photographs to be taken which may be used for medical publications, lay publications, education, or during lectures. I understand that I will not be entitled to any payment as a result of any of these images.

Because this therapy for wrinkles is considered a cosmetic procedure, insurance does not pay for treatment. Payment at the time of service is requested for all patients.

By signing below, I agree that I have read and understand the above information, and that my questions have been fully answered to my satisfaction. I understand that the practice of medicine and surgery is not an exact science and that results are not guaranteed. I agree to be personally and fully responsible for all fees.

Signature of Patient _____ Date_____
Signature of Witness _____ Date_____