

## BOTULINUM TOXIN "A" MEDICAL HISTORY

Name \_\_\_\_\_ Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Email \_\_\_\_\_  
Home Phone \_\_\_\_\_ Work/Cell Phone \_\_\_\_\_  
Primary Physician's Name \_\_\_\_\_ Phone # \_\_\_\_\_  
DOB \_\_\_\_\_ Age \_\_\_\_\_ Ht \_\_\_\_\_ Wt \_\_\_\_\_

Please list all medications you are currently taking: \_\_\_\_\_  
\_\_\_\_\_

Allergies: \_\_\_\_\_ Are you on Antibiotics at this time? \_\_\_\_\_

**Circle any of the following illnesses you have or have ever had in the past:**

Myasthenia Gravis    Hepatitis    Eye Disease    Autoimmune Disease    Vision Problems  
Numbness    Muscle Weakness    Multiple Sclerosis    Amyotrophic Lateral Sclerosis (ALS)  
Parkinson's Disease    Neurological Disorders    Lambert-Eaton Syndrome  
Allergies to Human Albumin or Bovine (Cow's Milk)

List and/or Explain Other Medical Conditions not listed above: \_\_\_\_\_  
\_\_\_\_\_

Previous Hospitalizations/Operations: \_\_\_\_\_  
\_\_\_\_\_

WOMEN: Are you Pregnant, Trying to get Pregnant, or Lactating (nursing)? \_\_\_\_\_

Have you had Plastic Surgery or other surgery to your face/neck areas? If so, when? \_\_\_\_\_  
\_\_\_\_\_

Had Botox® injections before? \_\_\_\_\_ Last treatment? \_\_\_\_\_ What Areas? \_\_\_\_\_  
Were you happy with previous Botox® treatments? \_\_\_\_\_ Explain \_\_\_\_\_  
\_\_\_\_\_

Have you ever had eyelid/eyebrow droop after Botox®? \_\_\_\_\_

Do you show a lot of upper eye lid when eyes are open? \_\_\_\_\_

Do your eyelids feel extra heavy when you don't get enough sleep? \_\_\_\_\_

Do your eyelids droop without sleep? \_\_\_\_\_

Areas of special concern to patient? \_\_\_\_\_

I understand the information on this form is essential to determine my medical and cosmetic needs and the provision of treatment. I understand that if any changes occur in my medical history/health I will report it to the office as soon as possible. I have read and understand the above medical history questionnaire. I acknowledge that all answers have been recorded truthfully and will not hold any staff member responsible for any errors or omissions that I have made in the completion of this form.

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

## **CONSENT TO BOTULINUM TOXIN "A" TREATMENT**

Botulinum Toxin "A" is a neurotoxin produced by the bacterium clostridium A. Botulinum Toxin A is FDA approved for treatment of rhytids (wrinkles) located between the eyebrow, aka, the Glabella region. Other areas are commonly treated with botulinum toxin A and this is considered off-label use. Botulinum Toxin A can relax the muscles on areas of the face and neck which cause wrinkles associated with facial expressions. I understand that Botulinum Toxin "A" cannot improve sagging skin or wrinkles caused by aging or sun damage and understand they are unrelated to muscle contraction. Treatment with Botulinum Toxin "A" can cause your facial expression lines or wrinkles to essentially disappear. Areas most commonly treated are: a) glabellar area of frown lines, located between the eyebrows; b) crow's feet (lateral areas of the eyes); and c) forehead wrinkles, however, botulinum may also be used in other facial areas. Botulinum Toxin "A" 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, results generally last 3-4 months and in some individuals may last longer. With repeated treatments, the results may also 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 and in this specific instance such risks include but are not limited to: 1. Post treatment discomfort, swelling, redness, and bruising, 2. Double Vision 3. Rarely, weakened tear duct 5. Post treatment bacterial, and/or fungal infection requiring further treatment 6. Allergic reaction 7. Minor temporary droop of eyelid(s), eyebrow (s), or corner of the mouth in approximately 2% of injections, this usually lasts 2-3 weeks 8. Occasional numbness of the forehead lasting up to 2-3 weeks, 9. Transient headache, and 10. Flu-like symptoms may occur.

### **PHOTOGRAPHS**

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

### **PREGNANCY, ALLERGIES & NEUROLOGIC DISEASE**

I am not aware that I am pregnant and I am not trying to get pregnant, I am not Lactating (nursing), have any significant Neurological disease (s) including but not limited to Myasthenis Gravis, Multiple Sclerosis, Lambert-Eaton Syndrome, Amyotrophic Lateral Sclerosis (ALS), Parkinson's or that I have any allergies to the toxin ingredients, or to human albumin and have never had a reaction to Botulinum Toxin "A" in the past.

### **PAYMENT**

I understand that this is an "elective" cosmetic procedure and that payment is my responsibility and due at time the services are rendered.

### **RESULTS**

I am aware that when small amounts of purified botulinum toxin A is injected into a muscle it causes weakness/relaxation of that muscle. This appears in 2 – 10 days and can last 3-4 months, but can be shorter or longer. I understand that the length of response may vary from patient to patient and from one treatment to the next. In a very small number of individuals, the injection does not work as satisfactorily or for as long as usual and rarely, there are some individuals who do not respond at all. It is at the discretion of my practitioner as to whether or not a "touch-up" injection may be needed within the first 14 days of treatment, and I understand if that is the case, an additional charge may incur. 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 re-treatment is appropriate. I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made to me as to the results of the procedure. I understand that the success of the procedure is to some extent dependent upon my closely following instructions and that I must not perform any vigorous exercise and I must not massage or manipulate the area (s) of the injections for the 2-3 hours post-injection period. Additionally, utilizing the target muscle groups may help the toxin to take a greater affect.

I understand this is an elective procedure and hereby voluntarily consent to treatment with Botulinum Toxin "A" injections for the condition known as: Facial Dynamic Wrinkles. The procedure has been fully explained to me as well as the areas which are off label. I have read the above information and understand it. My questions have been answered satisfactorily. I accept the risks and complications of the procedure and I understand that no guarantees are implied as to the outcome of the procedure. I certify that I am over the age of 18 and am not under the influence of drugs or alcohol.

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Patient Name (Print)

Patient Signature

Date