

Name _____ DOB: _____ Date _____

What areas of your face are you most interested in treating?: _____

Why are you considering injections now?: _____

What are your current facial skin care products?: _____

FACIAL INJECTIONS HISTORY

Have you ever had any Dermal injections? Yes / No
If yes, please list last treatment date, and areas treated.

Were you satisfied with the results?

Have you ever had any Botox injections? Yes / No
If yes, please list last treatment date, and areas treated.

Were you satisfied with the results?

Have you ever had eyelid or eyebrow droop after Botox?
Yes / No

Do you ever have eyelid droop during the day or at the
end of the day? Yes / No

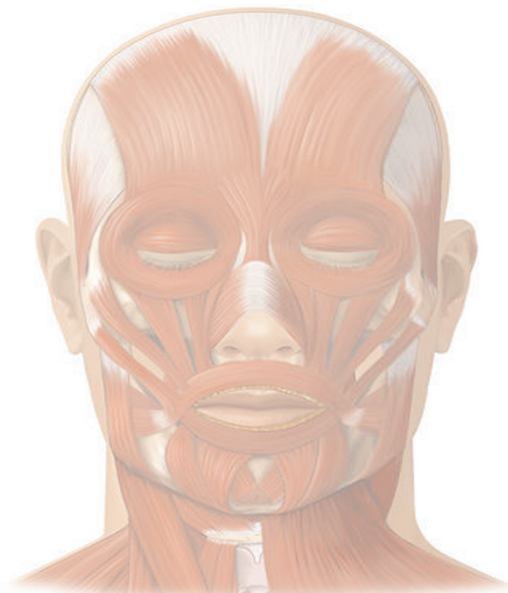
Have you ever had surgery to the face/neck? Please list.

Any Personal History of the following?

Yes No

- Bleeding disorder / Easy bruising
- Allergy to Beef/Dairy/Cow's milk products
- Allergy to Lidocaine
- Neurologic disorder
- Myasthenia gravis
- Lambert-Eaton Syndrome
- Keloid scarring
- Current use Clindamycin / Gentamicin
- Current use Donepezil (Aricept)
- Current use physostigmine (Eserine) eye drops
- Accutane use within the last 1 year
- Pregnant, Trying to get pregnant, or Nursing
- History of Cold Sores
- Herbal Supplement use (Please list)

Patient Signature: _____



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Botox Dilution Used

	Saline	# Units/1.0ml	# Units/0.1ml
<input type="radio"/>	1.0 cc	100 U/1.0ml	10 U/0.1ml
<input type="radio"/>	2.0 cc	50 U/1.0ml	5 U/0.1ml
<input type="radio"/>	2.5 cc	40 U/1.0ml	4 U/0.1ml
<input type="radio"/>	4.0 cc	25 U/1.0ml	2.5 U/0.1ml
<input type="radio"/>	5.0 cc	20 U/1.0ml	2 U/0.1ml

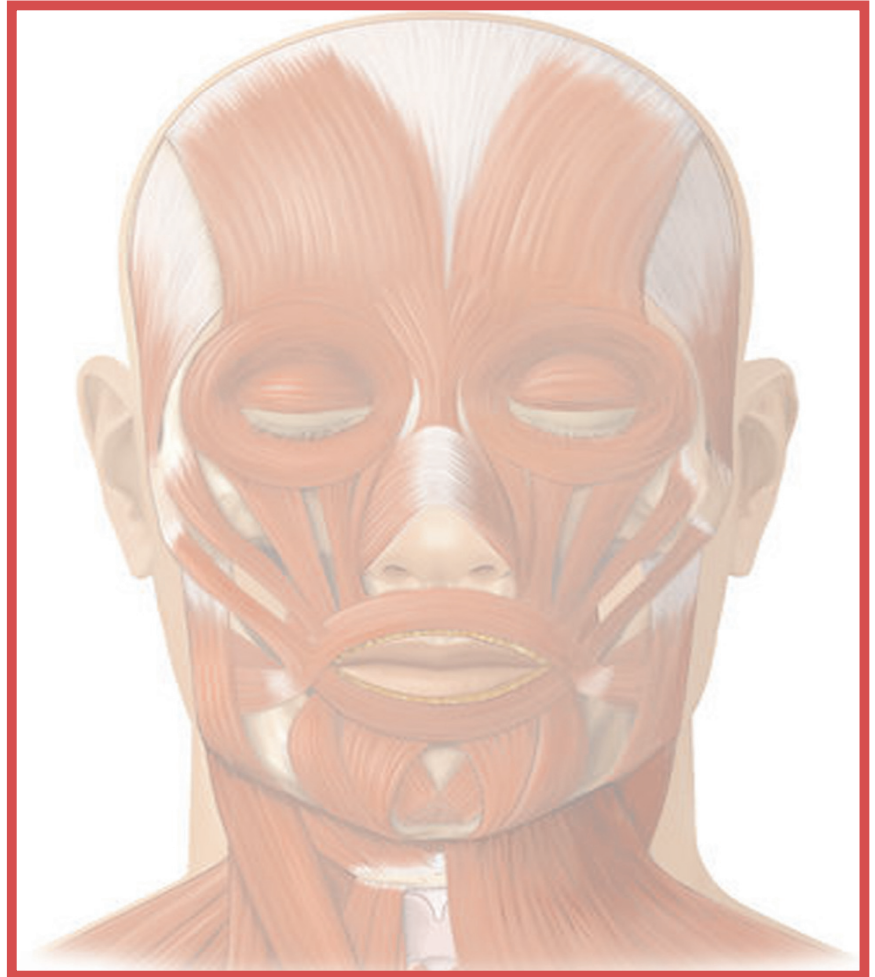
Medication Information

Lot Number

Expiration Date

Place Label Here

Total Units (Forehead) _____
 Total Units (Glabella) _____
 Total Units (Crows Feet) _____(R) _ _____(L)
 Total Units (Other Area) _____
TOTAL UNITS = _____



Physician Signature