UNIVERSITY OF IOWA HEALTH CARE | Aesthetic Consultants of Iowa PLASTIC AND RECONSTRUCTIVE SURGERY

Facial Injections

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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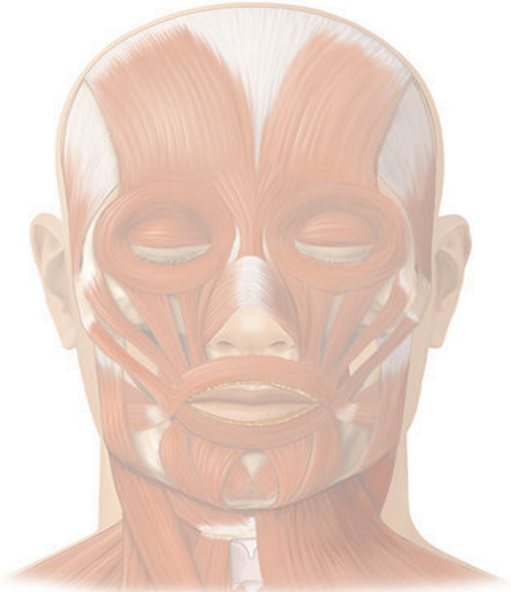

Provider Reviewed _____

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Injection Chart

Name _____ **DOB:**_____ **Date**_____

Botox Dilution Used

	Saline	# Units/1.0ml	# Units/0.1ml
○	1.0 cc	100 U/1.0ml	10 U/0.1ml
○	2.0 cc	50 U/1.0ml	5 U/0.1ml
○	2.5 cc	40 U/1.0ml	4 U/0.1ml
○	4.0 cc	25 U/1.0ml	2.5 U/0.1ml
○	5.0 cc	20 U/1.0ml	2 U/.01ml

Medication Information

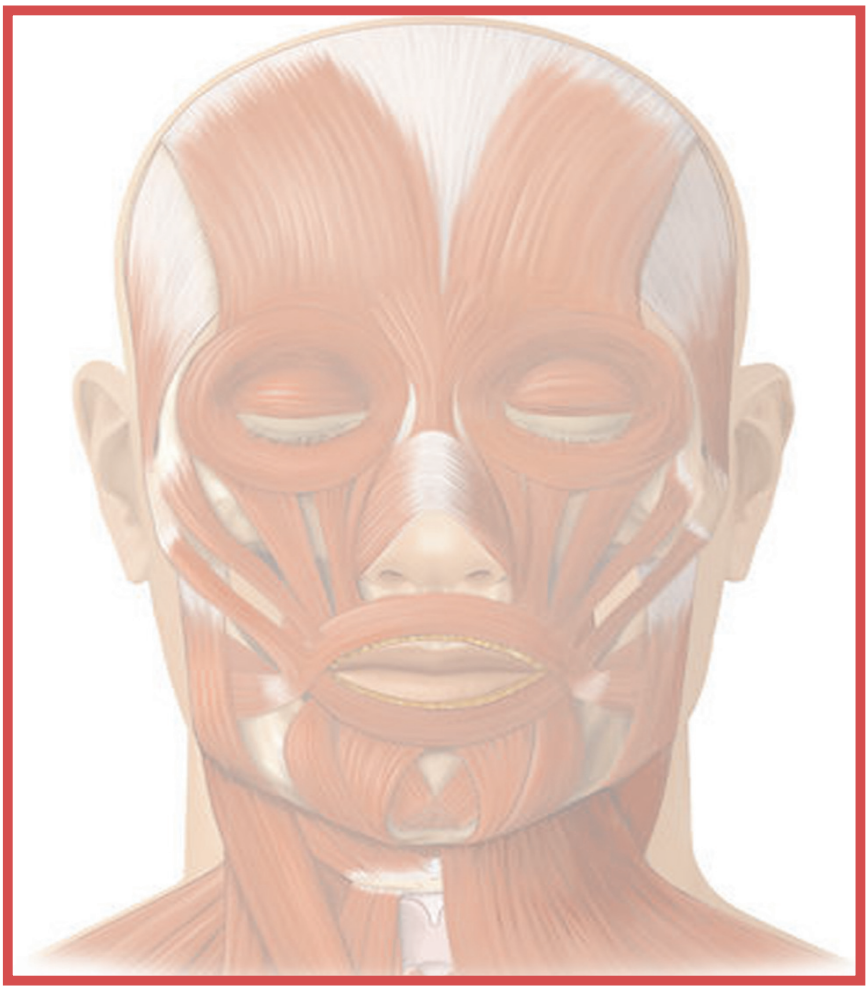
_____

Lot Number

_____

Expiration Date

Place Label Here



Total Units (Forehead) _____

Total Units (Glabellar) _____

Total Units (Crows Feet) _____(R) _ _____(L)

Total Units (Other Area) _____

TOTAL UNITS = _____

_____

_____

_____

_____

Physician Signature