Med Physique Center for Aesthetics

MEDICAL & PERSONAL HISTORY

Name: _____ **Date:** _____

Birth Date (mm/dd/yyyy)_____/_____/_____

Address:_____

City:_____ State: _____ Zip Code: _____

Phone: (Home)_____ (work)_____(Cell)_____

Email Address:_____Referred by:_____

Emergency Contact: _____Phone: _____

Current medications being taken and reason for each:

_____

_____

_____

Please list any allergies, including allergies to medications, you have or may have experienced in the past: _____

_____

_____

Have you ever taken any of the following? If so, list date of last dosage: Retin

A/Differin	Renova/Retinoids	Accutane
Birth Control	Hormones/Hormone Therapy	Hydroquinone
Alpha/Beta Hydroxy Acids	Aspirin Therapy	Tetracycline/Vectrin

Did you suffer any complications from any of the above? If so, please explain.

_____

_____

_____

Have any of the following conditions ever applied to you? If so, please explain.

Acne	Cold Sores	High Blood Pressure	Skin Cancer/Atypical
Allergies	Contacts	Rosacea	Lesions
Blood Disorders	Diabetes	Pregnancy	Smoking
Bruise Easily	HIV Positive	Predisposition to Keloids	PIH

Are you currently being treated for any other conditions not listed? If so, please explain:

Have you ever undergone (or have the intention of undergoing within the next year) any of the following procedures or other surgeries listed below?

Microdermabrasion	Chemical Peels	Laser Resurfacing	Collagen/Botox
Face Lift* (Full or Partial)	Permanent Makeup Application	Endermologie on the Area to be Treated	Other Surgeries on the Area to be Treated
Hair Removal	Vein Treatment		

If so, were there any complications suffered as a result of the procedure or recovery process? If so, please explain.

Is there any other information that you feel may be related to or is pertinent to your treatment? If so, please explain.

Notes:

(Patient Signature) **(Date)**

INFORMED CONSENT FOR BOTOX® Botox® (Botulinum Toxin type A) is the only FDA approved treatment for the temporary reduction of moderate to severe forehead lines and wrinkles, frown lines and crow's feet. It is accomplished by injecting small amounts of Botox® solution in the area of the wrinkles. Botox® works by temporarily relaxing the facial muscles that are responsible for producing the wrinkling of the facial skin, thus producing the appearance of smoother, flatter skin. Advisory: It is recommended that you not take aspirin, non-steroidal anti-inflammatory medication, or any blood anti-coagulants before this procedure. These medications may increase the risk of bruising. If you are able to stop these medications, you should do so one (1) week before the procedure. Patients with certain medical conditions may not have this procedure done. These include those with any type of facial paralysis such as Bell's palsy, Guillain-Barre Syndrome and Myasthenia Gravis. Patients who are pregnant or breastfeeding should not use Botox®. The effects of the procedure typically last about 3-5 months. Be advised that it is possible for a patient to experience some adjacent facial muscle relaxation in areas other than the intended target muscle. Most common is the effect of ptosis, or eyelid droop. This condition occurs in less than 3% of injections. It is temporary and will usually resolve before the Botox® wears off. The main side effects after injection are pain from injection and bruising, which are usually minimal and temporary. Localized hypersensitivity to the saline may also occur temporarily By signing this consent, you agree that you have read the attached information regarding Botox® injection, understand that the use of aspirin, non-steroidal anti-inflammatory drugs or blood thinning medication within the last 3 days, may increase the risk of post-injection bruising. You understand the procedure and its side effects. The personnel at Med Physique have been provided with a thorough and truthful medical history. Additional injections may be necessary, for which Med Physique will charge a retouch fee, if optimal effect is not reached in 10 to 14 days. Botox® has only a temporary effect that lasts approximately 3-5 months and you will need to repeat injections 3-4 times a year to continue the effect. You certify that you have read the above consent and fully understand it and the decision to proceed is based solely on information in this informed consent. You have been given ample opportunity for discussion and all of your questions have been answered to your satisfaction. You hereby consent to the treatment or care described in this document. You hereby assume all PATIENT TO COMPLETE Page 2 of Botox® Consent Risks, hazards and costs of care or expense associated with or which may arise from such treatment, hereby releasing the personnel and consultants and any sponsoring health care facility or institution and its affiliates and all of their agents and employees from any liability from said treatment except where such risks and hazards are the proximate result of gross negligence. This constitutes the full disclosure and supersedes any previous verbal or written disclosures, advertising or marketing materials prepared by us or other. It is understood that our programs are specialty services and do not have responsibility for your comprehensive medical care. If you have any medical problems that arise while participating, please keep us informed. If an urgent medical problem should arise and you have a concern that it may be related to your care, please call us at 512-453-7000 and contact your primary care physician or go to a healthcare facility to have the problem assessed immediately.

_____ _____

Client Signature **Date**

COSMETIC INJECTIONS

For this and all future injections of Juvederm Ultra, Juvederm Ultra Plus, Juvederm XC, Volbella, Vollure, Kybella and BOTOX® Cosmetic, I understand that: I will be injected with the utmost skill and care. Each person's body reacts differently. The effect of the injection may not be exactly the same every time. No guarantees are made regarding the results or their longevity. No refunds will be made Touch-ups will incur an additional charge per unit or per syringe_____

Client Signature

Med Physique Center for Aesthetics DERMAL FILLER CONSENT FORM All the dermal fillers used in our practice are made of substances naturally found in your body. Over time, these will be broken down naturally by your body. Although the most frequently treated areas are nasolabial folds, oral commissures, and lips, the area around the cheekbones may be injected to give the face a younger, fuller and more natural appearance. You may experience discomfort during injection. Anesthetic is used on the skin and is mixed with the filler to minimize this discomfort. The procedure takes about 30-60 minutes. 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) Post treatment bacterial, viral, and/or fungal infection requiring further treatment, 3) Allergic reaction The most common symptoms include temporary injection site reactions such as swelling, pain/tenderness, redness, and lumps/bumps which are normal. These reactions are typically mild and go away within 3 days. Consistent icing of these areas in the first 12 hours substantially reduces these symptoms. Some patients may experience one or more of these symptoms for a longer period of time; however, these symptoms typically go away without treatment. Patients using aspirin, ibuprofen, and other non-steroidal anti-inflammatory drugs, or warfarin (a blood thinner) prior to treatment with may notice increased bruising or bleeding at or near the injection sites. MEDICAL CONDITIONS I am not aware that I am pregnant, have any significant medical conditions or severe allergies. I understand that my medical history is essential to determine whether I should receive this treatment and to the best of my knowledge have shared this history. I will not hold any staff member responsible for any errors or omissions that I have made. A local anesthetic such as Lidocaine is typically used on the skin as well as being mixed with the filler to provide minimize discomfort at the injection site. Please tell your doctor if you have had any previous reactions to anesthetics. PHOTOGRAPHS I authorize the taking of clinical photographs for my medical record only. These photos may not be used for any other purpose without my written permission. CONSENT I hereby voluntarily consent to treatment with Dermal Filler injection. The procedure has been explained to me. I have read the above and my questions have been answered satisfactorily. I accept the risks and complications of the procedure.

_____ _____

Client Signature **Date**

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Printed Client Name