



MEDICAL HISTORY FORM

Last Name: _____ First Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Telephone: Home: _____ Work: _____ Cell: _____

Date of Birth: _____ Sex: Female ____ Male ____

Family Doctor: _____ Phone: _____

Pharmacy: _____ Phone: _____

Emergency Contact: _____ Phone: _____

Which body area/areas or condition would you like treated? _____

Please answer all of the following questions

YES NO

1. Do you have **ANY** current or chronic medical illnesses? YES NO

Disclose any history of heat urticaria, diabetes, autoimmune disorders or any immunosuppression, blood disorders, cancer, bacterial or viral infections, medical conditions that significantly compromise the healing response, skin photosensitivity disorders, or any other condition or illness.

Please List: _____

2. Do you have **ANY** current or chronic skin conditions? YES NO

Also disclose any history of vitiligo, eczema, melasma, psoriasis, allergic dermatitis, any diseases affecting collagen including Ehlers-Danlos syndrome, scleroderma, skin cancer, or any other skin condition.

Please List: _____

3. Are you currently under a doctor's care? If so, for what reason? YES NO

4. Do you take/use **ANY** medications (prescriptions and nonprescriptions), vitamins, herbal or natural supplements, on a regular or daily basis? YES NO

Please List: _____

5. Are there any topical products (both medical and non-medical) that you use on your skin on a regular or daily basis? YES NO

Please List: _____

6. Do you take/use **ANY** systemic/oral steroids (e.g., prednisone, dexamethasone)? YES NO

7. Do you have **ANY** allergies to medications, foods, latex or other substances? YES NO

Please List: _____

8. (For women) are you or could you be pregnant? YES NO

9. (For women) are menstrual periods irregular, or have you ever been diagnosed with Polycystic Ovarian Disorder? YES NO

10. Do you have a history of herpes I or II in the area to be treated? YES NO

11. Do you have a history of keloid scarring or hypertrophic scar formation? YES NO

12. Do you have a history of light induced seizures? YES NO

13. Do you have any open sores or lesions? YES NO

14. Do you have any history of radiation therapy in the area to be treated? YES NO

MEDICAL HISTORY, CONTINUED

YES NO

15. In the last six (6) months, have you used any of the following:
anticoagulants or blood-thinning medications; photosensitizing medications; or anti-inflammatory
or blood thinning medications? YES NO
Please List product name and date last used: _____
16. In the last three (3) months, have you used any of the following products:
glycolic acid or other alphahydroxy or betahydroxy acid products;
exfoliating or resurfacing products or treatments? YES NO
Please List product name and date last used: _____
17. Do you have or have you ever had any permanent make-up, tattoos, implants,
or fillers,including, but not limited to, collagen, autologous fat, Restylane®, etc.?
If yes, please list locations on or in the body and dates: _____ YES NO
18. Do you have or have you ever had any Botulinums, such as Botox® or Dysport®?
If yes, please list locations on or in the body and dates: _____ YES NO
19. Have you taken Accutane® (or products containing isotretinoin) in the last 12 months? YES NO
20. Have you taken Tretinoin (like Retin-A, Renova) in the last 6 months? YES NO
21. Have you had any unprotected sun exposure, used tanning creams (including
sunless tanning lotions) or tanning beds or lamps in the last 4-6 weeks? YES NO
22. Do you have a pacemaker? YES NO

Please include your email address to receive appointment confirmations, and monthly information on
special pricing and/or special events:

_____ @ _____

How did you hear about us? _____

Signature: _____ Date: _____

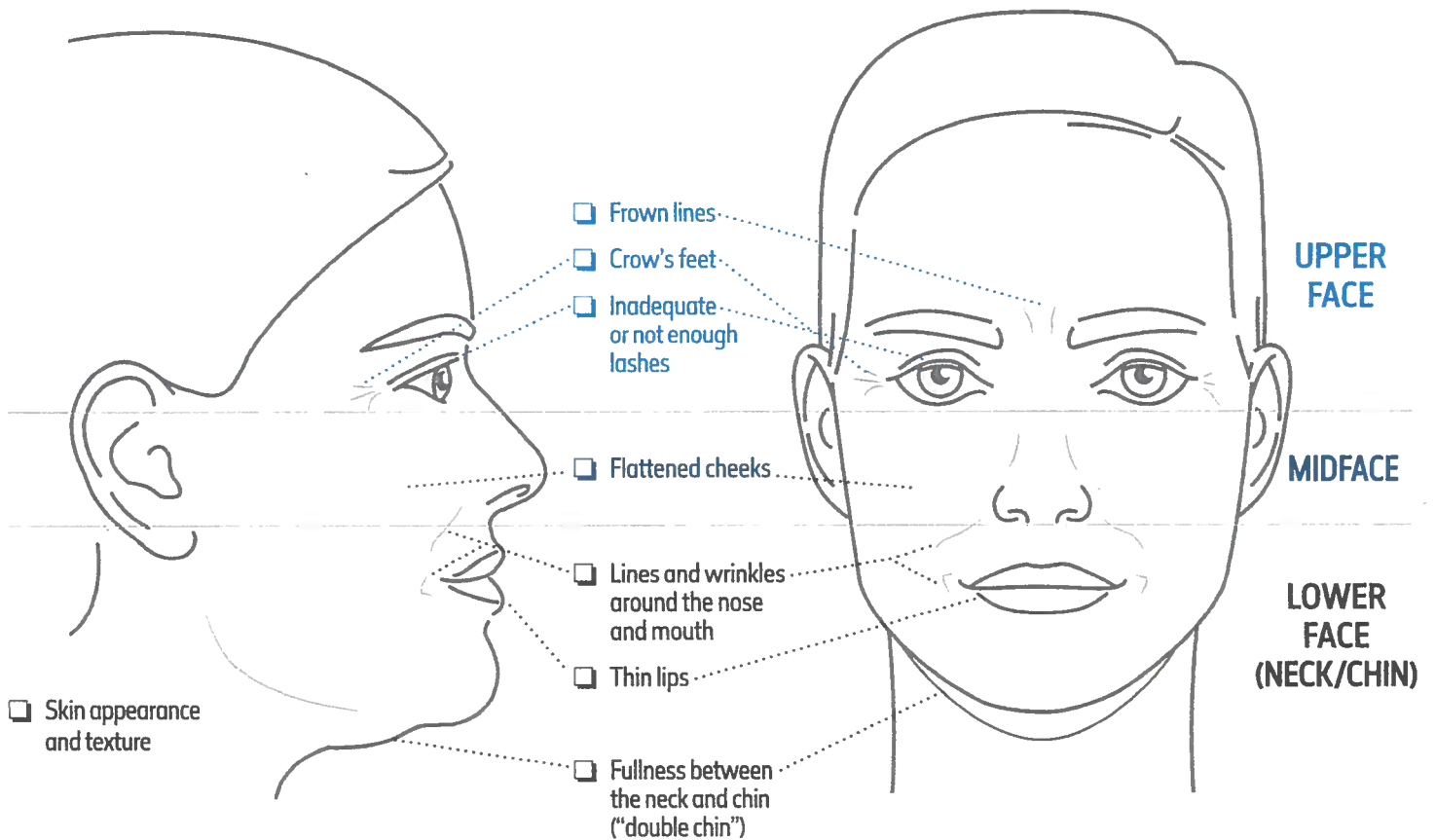
SELF-ASSESSMENT

NAME: _____ DATE OF BIRTH: _____ DATE: _____

What brings you in today? _____

Select which areas of the face concern you on the diagram below.

By sharing how you see yourself, we can best evaluate your aesthetic goals and select an appropriate treatment for you.



Please complete and return this form to the front office before your consultation.

Ocean Med Spa

915 E Ocean Blvd · Stuart, FL 34996

CONSENT TO BOTULINUM TOXIN "A" TREATMENT

Botulinum Toxin a neurotoxin produced by the bacterium Clostridium A, can relax the muscles on areas of the face which cause wrinkles associated with facial expressions. Botulinum toxin treatments (Botox®, Xeomin & Dysport) can cause our facial expression lines or wrinkles to essentially disappear. Areas most frequently treated are: a) glabellar area of frown lines, located between the eyes; b) crow's feet (lateral areas of the eyes); and c) forehead wrinkles. Botox®, Xeomin & Dysport 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 and the results last 3-5 months. With repeated treatments, the results may 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) Post treatment bacterial, viral and/or fungal infection requiring further treatments, 3) Allergic reaction, 4) Minor temporary droop of eyelid(s) in approximately 2% of injections, this usually lasts 2-3 weeks, 5) Occasional numbness of the forehead lasting up to 2-3 weeks, 6) Transient headache, and 7) Flu-like symptoms may occur.

PHOTOGRAPHS

I authorize the taking of clinical photographs and their use for scientific 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, have any significant Neurological disease, or have any allergies to the toxin ingredients or to human albumin.

PAYMENT

I understand that this procedure is cosmetic and that payment is my responsibility.

RESULTS

I am aware that when small amounts of purified botulinum toxins are injected into a muscle it causes weakness or paralysis of the muscle. This appears in 3-10 days and usually last 3-5 months but can be shorter or longer. In a very small number of individuals, the injection does not work as satisfactorily or for as long as usual. 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 retreatment is appropriate. I understand that I must stay in the erect posture and that I must not manipulate the area of the injection for the four hours post-injection period.

CONSENT TO BOTULINUM TOXIN "A" TREATMENT

I hereby voluntarily consent to treatment of Botulinum Toxin injections for the condition known as: Facial Dynamic Wrinkles. The procedure has been explained to me. I have read the above and understand it. My questions have been answered satisfactorily. I accept the risks and complications of the procedure.

Client Signature

Date

Witness Signature

Date