Massey Medical

Medical History (Botox)

Name: _____ **Date:** _____

Date of Birth: _____ **Phone:**_____

MEDICAL INFORMATION: I am interested in the following services: Juvederm: ____ Botox: ____

NO **YES**

____ ____ Allergies – history of severe allergy or anaphylaxis. (Albumin or Egg Allergy) ?

Please List:_____

____ ____ Aspirin, Ibuprofen, NSAIDS, Anticoagulants: If yes, when?_____

____ ____ Autoimmune disease, HIV, Lupus, Hepatitis

____ ____ Bruise easily, Cuts

____ ____ History of Keloids scarring

____ ____ Currently on immunosuppressive therapy

____ ____ History of oral herpes (fever blisters)

____ ____ Currently under the care of a physician? Who:_____

____ ____ Currently taking any medication (including OTC & Herbal supplements taken regularly)? Please List:

_____

____ ____ Currently Pregnant or Breast Feeding?

____ ____ History of generalized impairment of muscle strength (Myasthenia Gravis, Eaton-Lambert syndrome, ALS, Guillian-barre Syndrome, Bell's Palsy, etc.)

____ ____ Have you recently finished, or are currently taking antibiotics

____ ____ Are you planning Lasik surgery

____ ____ Any condition not listed: _____

Reviewed by: _____ Date: _____

Massey Medical

CONSENT FOR PHOTOGRAPHIC USE

I, _____, give Massey Medical permission to use my pictures for:

YES	**NO**	
_____	_____	Demonstration to other clients and professionals of results,
_____	_____	In-office photo book
_____	_____	Newspapers, internet, magazines, Facebook, etc
_____	_____	Other marketing releases

I hereby give Massey Medical and related organizations use of my name and photographs of myself for professional education, marketing, advertising and other purposes and/or educational purposes and do release Massey Medical from any confidential information that is released. I hereby hold harmless Massey Medical from any detrimental consequences that may be experienced as a result of using that material and its actions. I am aware that photographs of injection sites before and after injection will be required and will remain in my chart. My photographs will only be used for advertising, marketing, or educational purposes if I give consent, by marking the appropriate section above. I hereby do agree that all information was given voluntarily.

Patient Name:_____ Today's Date:_____

Patient Signature:_____ Date of Birth:_____

Massey Medical

INFORMED CONSENT FOR BOTOX®

For this and all future injections of Botox® (Botulinum Toxin type A) I understand the following: Botox (Botulinum Toxin A) is the only FDA approved treatment for the temporary reduction of moderate to severe forehead lines and wrinkles, (glabellar 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. I understand that I will be injected with Botulinum A Toxin (Botox) in the glabella muscles, forehead, or crows feet (around the eyes) to paralyze these muscles.

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.

The possible side effects of Botox include but are not limited to:

1. Risks: I understand there is a risk of swelling, rash, headache, local numbness, pain at the injection site, bruising, respiratory problems, and allergic reaction.

2. Infection: Infections can occur which in most cases are easily treatable but in rare cases a permanent scarring in the area can occur.

3. Most people have lightly swollen pinkish bumps where the injections went in, for a couple of hours or even several days.

4. Although many people with chronic headaches or migraines often get relief from Botox, a small percent of patients get headaches following treatment with Botox, for the first day. In a very small percentage of patients these headaches can persist for several days or weeks.

5. Local numbness, rash, pain at the injection site, flu like symptoms with mild fever, back pain.

6. Respiratory problems such as bronchitis or sinusitis, nausea, dizziness, and tightness or irritation of the skin.

7. Bruising is possible anytime you inject a needle into the skin. This bruising can last for several hours, days, weeks, months and in rare cases the effect of bruising could be permanent.

8. While local weakness of the injected muscles is representative of the expected pharmacological action of Botox, weakness of adjacent muscles may occur as a result of the spread of the toxin.

9. Treatments: I understand more than one injection may be needed to achieve a satisfactory result.

10. Another risk when injecting Botox around the eyes included corneal exposure because people may not be able to blink the eyelids as often as they should to protect the eye. This inability to protect the eye has been associated with damage to the eye as impaired vision, or double vision, which is usually temporary. This reduced blinking has been associated with corneal ulcerations. There are medications that can help lift the eyelid, however, if the drooping is too great the eye drops are not that effective. These side effects can last for several weeks or longer. This occurs in 2-5 percent of patients.

11. I will follow all aftercare instructions as it is crucial I do so for healing. As Botox is not an exact science, there might be an uneven appearance of the face with some muscles more affected by the Botox than others. In most cases this uneven appearance can be corrected by injecting Botox in the same or nearby muscles. However in some cases this uneven appearance can persist for several weeks or months.

This list is not meant to be inclusive of all possible risks associated with Botox as there are both known and unknown side effects associated with any medication or 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. In the 16 years that Botox® has been approved for use, there has never been a reported allergic reaction.

By signing this consent, you agree that you have read the information regarding Botox® injection, and 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 Massey Medical have been provided with a thorough and truthful medical history. Additional injections may be necessary, for which Massey Medical will charge a retouch fee, if optimal effect is not reached in 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.

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 (for Dermal Fillers)
- Botox touch-ups will be $10.00 per unit.

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 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. 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 423-994-8243, and contact your primary care physician or go to a healthcare facility to have the problem assessed immediately.

_____ _____

Patient Name (Print) Date of Birth

_____ _____

Patient Signature Date

_____

Witness Signature