Evergreen Primary Care and Wellness
2450 Atlanta Hwy, Suite 803
Cumming, GA 30040
P: (470) 253-7944 F: (678) 807-6144

BRIEF MEDICAL HISTORY:

Name _____

Address _____

City/State _____ Zip _____

Phone _____ Age _____ Ht _____ Wt _____

Email Address _____

MEDICATIONS:

_____

_____

ALLERGIES:

_____

Women are you pregnant or lactating? _____
Physician's Name _____

Circle any of the following illnesses you have or have ever had in the past (or family history):

Myasthenia Gravis	Hepatitis	Eye Disease	Autoimmune Disease
Numbness	Vision Problems	Muscle Weakness	
Amyotrophic Lateral Sclerosis (ALS)		Eaton Lambert Disorder	

I am not on Aminoglycosides or any other antibacterial medication to treat bacterial infections.
Explain: _____

_____

Previous Hospitalization/Operations:

_____

_____

I understand the information on this form is essential to determine my medical and cosmetic needs and the provision of treatment. I understand that if any changes occur in my medical history/health I will report it to the office as soon as possible. I have read and understand the above medical questionnaire. I acknowledge that all answers have been recorded truthfully and will not hold any staff member responsible for any errors or omissions that I have made in the completion of this form.

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Client Signature: _____ Date: _____

Dermal Filler Patient History

Name: _____ Date: _____
Address: _____
Telephone: _____ Cell: _____
Date of Birth: _____
Consent signed: Yes No Date: _____
Previous Dermal Filler Yes No Date: _____
Complications: Yes No Date: _____
Type Dermal Fillers: _____
History of Anaphylactic Shock: Yes No Date: _____
History of Allergies: Yes No Date: _____

Medications

Aspirin Yes No
Anti-Inflammatories Yes No
Anticoagulants Yes No
Steroids Yes No
Non-Steroidal Yes No
(i.e. Advil, Aleve, Celebrex)

_____
_____
_____
_____

Supplements

Gingko Biloba Yes No
Vitamin A Yes No
Vitamin E Yes No
Garlic Yes No
Flax Oil Yes No

_____
_____
_____
_____

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Dermal Filler Patient History (Continued)

Do you have at present, any history of the following medical conditions?

Have you had in the past, any history of the following medical conditions?

1. Multiple Severe Allergies		Yes	No
2. HX of Herpes around the Lips		Yes	No
3. On Immunosuppressive Therapy	Yes	No	
4. Autoimmune Disease	Yes	No	
5. Medical History	Yes	No	

(if answered Yes to any one of the above please explain below)

Comments:

_____
_____
_____
_____
_____
_____
_____
_____

I have answered the above questions to the best of my knowledge.

_____ _____

Signature Date

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PATIENT PRE AND POST TREATMENT INSTRUCTIONS FOR DERMAL FILLERS

Recommendations for a few simple guidelines and both pre and post-procedure. These can make the difference between a good result and a fantastic one.

PRE-TREATMENT INSTRUCTIONS

- One week before exclude: Aspirin (Advil, Aleve, etc.), Gingko Biloba, garlic, flax oil, cod liver oil, vitamin A, vitamin E and any other essential fatty acids.
- Avoid Chemical Peels and Laser 1 –2 weeks prior to Dermal filler treatment.

POST-TREATMENT INSTRUCTIONS

Immediately after your procedure and for 24 hours you should avoid the following:

- Strenuous Exercise
- Sun exposure/heat exposure/tanning beds
- Alcoholic Beverages
- Massaging/pressing areas treated
- Extreme cold temperatures
- 48 hours after your procedure you may begin adding Gingko Biloba, garlic, flax oil, cod liver oil, vitamin A, vitamin E or any other essential fatty acids.
- If Laser treatment, Chemical Peel or any other procedure is considered after Dermal filler treatment, the risk of eliciting an inflammatory process may be possible. Consider such treatments 1 week before an/or after Dermal filler.

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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 can cause wrinkles associated with facial expressions. Treatment with Botox® can cause our facial expression lines or winkles 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® 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 ad 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 drop 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 ad 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 toxin (Botox®) 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 (cont.)

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I hereby voluntarily consent to treatment with Botox® injected 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