Patient Information

 Patient Name Date

 History of recent NSAID Y N Recent ASA Y N Pregnant Y N Patient initials

 Significant Medical History Current Medical History

Treatment History

 Patient’s first Dermal filler treatment: Y N Patient’s first Botox treatment: Y N

 Previous Dermal filler problems? Previous Botox problems?

 Date of last Dermal filler treatment Date of last Botox treatment

 Off label consent given Off label consent given

 Informed consent given Informed consent given



**Muscle Dosage Syringe**

 **(in units) Volume**

|  |  |  |
| --- | --- | --- |
| **Frontalis** |  |  |
| **Glabellar** |  |  |
| **(L) Orbicularis oculi** |  |  |
| **(R) Orbicularis oculi** |  |  |
| **Obicularis Oris** |  |  |
| **(L) Temporalis**  |  |  |
| **(R) Temporalis**  |  |  |
| **(L) Masseter**  |  |  |
| **(R) Masseter**  |  |  |

**Total units needed**:

Consent form complete? : Y  N 

**CONSULT YOUR ASSIGNED FACULTY MEMBER UPON COMPLETION OF THIS FORM BEFORE TREATING YOUR PATIENT.**

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