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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