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 filler treatment: Y ❑ N ❑

Previous filler problems? ___________________________________

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Date of last filler treatment __________________________________

Off label consent given______________________________________

Informed consent given______________________________________

Patient's first BTX treatment: Y ❑ N ❑

Previous BTX problems? _____________________________

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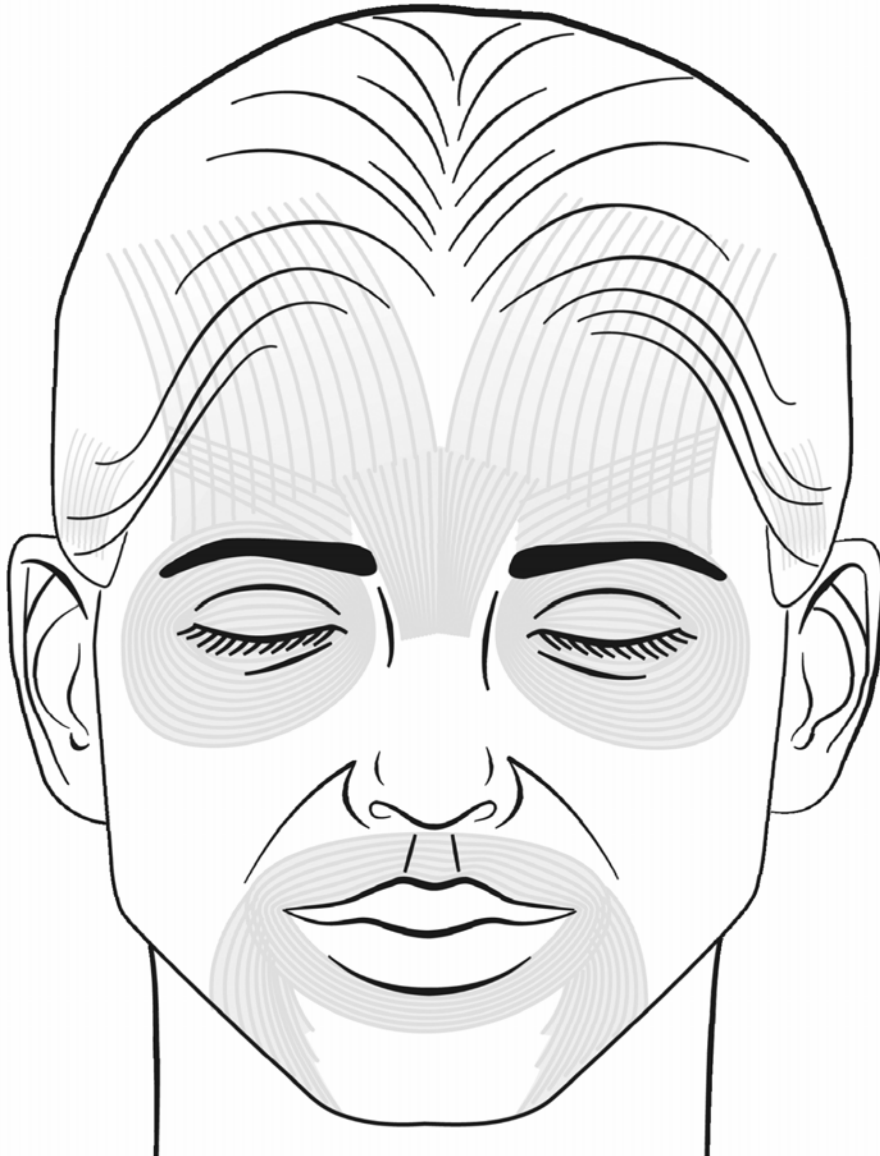
Date of last BTX treatment_____________________________

Off label consent given_________________________________

Informed consent given_________________________________



Patient Analysis and Operative Report

Patient Information

Patient Name____ Date______________________________

Current Treatment

Treated Feature	Product and Amount	Clinical Analyses / Comments
Frontalis / Horizontal Rhytids		
Brow Asymmetry		Right Lower? Left lower?
Glabellar Complex / Frown Lines		
Aperture Width		Right Lower? Left lower?
Crows Feet		
Nasalis (Bunny)		
Malar		
Nasolabial Folds		
Marionette Lines		
Vertical Lip Lines / Orbicularis Oris		
Vermillion Border		
Lip		
Oral Commissures / Mouth Corners		
Chin		
Platysma Bands		
Necklace Lines		

Product Information

Product Name	Product Lot Number/Label	Product Expiration Date
1		
2		
3		

Post Treatment Information

Complications	
Instructions given	
Follow-up Appointment	
Comments	

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Physician Signature