Cape Aesthetics

Heritage Square
2131 William Street, Cape Girardeau, MO 63703
573-803-0919

BOTOX® Cosmetic (onabotulinumtoxinA)
Patient History and Information

Name:_____ Date: _____

Date of Birth: _____

Email Address: _____

Address: _____

Telephone: _____ Cell: _____

May we email you? ❑ Yes ❑ No Or text you? ❑ Yes ❑ No

Consent signed: ❑ Yes ❑ No Date: _____
Previous Botox: ❑ Yes ❑ No Date: _____
Complications: ❑ Yes ❑ No Date: _____
History of Anaphylactic Shock: ❑ Yes ❑ No Date: _____

Allergies: ❑ No ❑ Yes: (list) _____

_____

Women: Are you pregnant or lactating? ❑ Yes ❑ No
Primary Physician:_____

Previous hospitalizations/operations: _____

_____

_____

Medications:

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

_____

_____

_____

Supplements:

Ginko Biloba ❑ Yes ❑ No
Vitamin A ❑ Yes ❑ No
Vitamin E ❑ Yes ❑ No
Garlic ❑ Yes ❑ No
Flax Oil ❑ Yes ❑ No

Do you presently have a history of any of the following medical conditions?
(Please check)

❑ History of Anaphylaxis
❑ Multiple Severe Allergies
❑ Facial Acne
❑ Hives
❑ Herpes
❑ Facial Rashes
❑ Autoimmune Disease
❑ Immunosuppressive Therapy
❑ Hepatitis
❑ Eye Disease
❑ Numbness
❑ Vision Problems
❑ Muscle Weakness
❑ Amyotrophic Lateral Sclerosis (ALS)
❑ Eaton Lambert Disorder
❑ Myasthenia Gravis
❑ Active Inflammatory process infection at proposed injection site
❑ Other Medical History

If answered yes to any one of the above please explain below:

Have you ever used Accutane? ❑ Yes ❑ No

If yes, when did you last use it? _____

What topical medications or creams are you currently using? ❑ RetinA ❑ Others (please list)

Have you ever had laser hair removal? ❑ Yes ❑ No

Have you used any of the following hair removal methods in the past six weeks?

❑ Shaving ❑ Waxing ❑ Electrolysis ❑ Plucking

❑ Tweezing ❑ Stringing ❑ Depilatories

Have you had any recent tanning or sun exposure that changed the color of your skin? ❑ Yes ❑ No

Have you recently used any self-tanning lotions or treatments? ❑ Yes ❑ No

Do you form thick or raised scars from cuts or burns? ❑ Yes ❑ No

Do you have hyper-pigmentation (darkening of the skin) or hypo-pigmentation (lightening of the skin) or marks after physical trauma? ❑ Yes ❑ No

If yes please describe: _____

Notify your physician if you have used any of the following in the last year (as they are a contraindication to some laser procedures) ❑ St. John's Wort ❑ Accutane ❑ Tetracycline

Check any of the following medications you have taken in the last 6 months (as they may increase hair growth):

❑ Birth Control Pills ❑ Androgens (Rogaine) ❑ Penicillin ❑ Cyclosporins ❑ Minoxidil

❑ Steroids ❑ Haldol ❑ Phenytoin ❑ Thyroid Medications

For our Female Clients

Are you pregnant or trying to become pregnant? ❑ Yes ❑ No

Are you using contraception? ❑ Yes ❑ No

Are you breastfeeding? ❑ Yes ❑ No

Have you ever smoked? ❑ Yes ❑ No How much? _____ How long? _____

Are you still smoking? ❑ Yes ❑ No When did you quit? _____

Who is your personal Physician: _____

Who is your personal Dermatologist: _____

I have answered the above questions to the best of my knowledge and understand that 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 on this form.

_____ _____

Signature Date

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Client Self Assessment

Do you have any of the following: ❑ Scars ❑ Stretch Marks ❑ Hyper Pigmentation

Do you suffer from?

❑ Acne ❑ Blackheads ❑ Whiteheads ❑ Milia ❑ Oiliness

❑ Rosacea ❑ Dehydration ❑ Eczema ❑ Cellulite

❑ Vein/Circulation Problems ❑ Psoriasis Where: _____

❑ Other _____

Have you ever received any of the following treatments?

❑ Facial ❑ Microdermabrasion ❑ Laser Surgery ❑ Chemical Peels

❑ Waxing ❑ Lash/Brow Tint ❑ Laser Hair Removal ❑ Vein Treatments

Please select the box that applies to you:

❑ I never tan, always burn ❑ I tan with difficulty, usually burn

❑ Average tanning, sometimes burn ❑ Easily tan, rarely burn

❑ I never burn

Please complete this section if you are interested in: INJECTABLES / LASERS / SKIN CARE

What is your skin type: ❑ Dry ❑ Oily ❑ Normal ❑ Combination

Are you using any topical creams, lotions or oral antibiotics for acne, skin cancer, anti-aging or hyper-pigmentation? Please list: _____

_____

_____

Have you ever had any of the following injectables or implants? (please check)

❑ Botox ❑ Juvederm ❑ Radiesse ❑ Perlane ❑ Silicone

❑ Collagen ❑ Hylaform ❑ Lipo Dissolve

❑ Other _____

If so, when was it done?_____ What area(s)_____

Please check the products you currently us and list the BRAND NAMES (if possible) of Cosmetic Products:

❑ Cleanser _____ ❑ Soap _____

❑ Moisturizer _____ ❑ Night Cream _____

❑ Toner _____ ❑ Eye Cream _____

❑ Mask _____ ❑ Glycolic Wash/Cleanser _____

❑ Astringent _____ ❑ Scrub _____

❑ Salicylic Wash/Cleanser _____ ❑ Sunscreen _____

❑ Vitamin A Cream _____ ❑ Vitamin C Creams _____

❑ Alpha or Beta Hydroxy Cream _____

Do you have any of the following chronic skin disorders?

❑ Psoriasis ❑ Dermatitis ❑ Eczema ❑ Keloid Scarring

❑ Cold Sores ❑ Sun Blisters ❑ Fever Blisters ❑ Herpes Simplex/Blisters

Have you ever undergone any of the following treatments?

❑ Microdermabrasion ❑ Acid Peel ❑ Cosmetic Surgery ❑ Accutane

Are you currently removing hair by any of the following methods?

❑ Laser Hair Removal ❑ Waxing ❑ Tweezing ❑ Nair Type Products ❑ Electrolysis

If so, when was it done?_____ What area(s)_____

What type of laser equipment was used?_____

PATIENT'S SIGNATURE:

To the best of my knowledge, the information provided above is true and accurate.

Patient Signature_____ Date _____

Provider Signature_____ Date _____

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

With my consent **Cape Medical Weight Loss & Family Practice** may use and disclose protected health information (PHI) about me to carry out treatment, payment, and healthcare operations (TPO). I understand that **Cape Medical Weight Loss & Family Practice** will retain my records for three full years after treatment cease. During this time, all personnel at **Cape Medical Weight Loss & Family Practice** will have complete access to my records. However, no third party shall receive copies of my records without my specific written consent.

Cape Medical Weight Loss & Family Practice wants to provide me with the utmost level of care. Thus, I am aware of the importance of disclosing my complete personal medical history. I will notify **Cape Medical Weight Loss & Family Practice** of changes in my healthcare as they occur during my treatment process. In addition, I will inform **Cape Medical Weight Loss & Family Practice** of all medications I am taking, including but not limited to: prescription and over-the-counter-drugs, herbs, supplements, vitamins, antibiotics and birth control. I understand any failure to do so on my part may result in an increase in the likelihood of side effects of complications during and post treatment.

With my consent, **Cape Medical Weight Loss & Family Practice** may call or email my home or other designated location and leave a message on voice mail or with me directly in reference to any items that assist the practice in carrying out TPO. I also consent to receive via mail or email items such as appointment reminders and/or patient statements or any forms that are requested by patient and/or practice. I have the right to request that **Cape Medical Weight Loss & Family Practice** restrict how it uses or disclosed my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

I understand and agree that no refund will be given for purchases made at **Cape Medical Weight Loss & Family Practice** on treatments, packages, services, gift certificates, or products. In-house credit only will be issued at Management's discretion. I understand that if a package discount is offered and I elect not to complete my package, treatments received will revert to regular per-treatment pricing and I will forfeit any package discounts. In addition, I understand and agree that **Cape Medical Weight Loss & Family Practice** reserves the right to refuse service to anyone prior to, during or after treatment(s) without explanation or cause.

I understand that photographs are necessary to document and track results and that **Cape Medical Weight Loss & Family Practice** may ask to photograph the area(s) being treated. Such photographs will be done using the utmost discretion and will never be released with out my full knowledge and expressed written consent. _____ *By initializing here, I consent to the discretionary use of my photos for before & after reference as needed.*

By signing this form, I am consenting to **Cape Medical Weight Loss & Family Practice's** use and disclosure of my PHI to carry out TPO. Additionally, my signature below indicates that I understand and agree with the above statements. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, **Cape Medical Weight Loss & Family Practice** may decline to provide treatment to me.

_____ _____

Patient's Signature Date

_____

Please Print Your Name

_____ _____

Provider's Signature Date

Cape Aesthetics

COSMETIC INJECTIONS

For this and all future injections of Juvederm Ultra, Juvederm Ultra Plus, Juvederm XC, Radiesse and BOTOX® Cosmetic, 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.
- Botox® touch-ups will be $13.00 per unit.

Client Signature

Date

BOTOX PRE-TREATMENT INSTRUCTIONS:

- To minimize the possibility of bruising, non-essential blood-thinning medications or supplements should be discontinued for 10-14 days prior to treatment if possible. These include Aspirin, Ibuprofen, Advil, Motrin, Midol, Aleve, Excedrin, Alka-Seltzer, Vitamin E, Green Tea, Garlic, Ginkgo Biloba, Ginseng, and St. Johns Wort. Please note that if you have been prescribed aspirin or another blood thinning medication such as Plavix or Coumadin for medical reasons, do NOT discontinue these medications. Please be advised the bruising does not affect the success of treatment.
- BOTOX® injections are generally very well tolerated with minimal discomfort. The use of a topical anesthetic is optional and generally not required. If you wish to apply a topical anesthetic at home, please notify your physician for a prescription.
- If you are pregnant, breast-feeding, or trying to become pregnant, please alert your physician, as you are not a candidate at this time.
- If you are unable to keep your appointment, please call 573-225-2442 to cancel or reschedule. Patients will be charged for any missed appointments that are not cancelled at least 24 hours in advance.

BOTOX POST-TREATMENT INSTRUCTIONS:

- Do not lie flat for at least four hours after your treatment. After four hours, you may resume your normal activities.
- Do not touch, massage, or in any way manipulate the injection sites.
- In order to minimize redness and bruising, avoid anything that will make your face or body flush such as direct sunlight, exercise, alcohol, hot showers, or spicy foods for 24 hours. If bruising does occur, it will go away in several days.
- You may apply cool water compresses to the treatment sites if they are uncomfortable or red.
- If you develop a headache, Tylenol is permissable. Do not take aspirin or ibuprofen as these agents my increase the risk of bruising.
- To enhance the uptake of BOTOX®, contract the muscles in the treated area frequently for two or three hours after treatment.
- As every patient has a different facial anatomy, asymmetry of the treatment result can occur with BOTOX® injections. Sometimes the correction is less that what you had expected or wanes quicker than you had expected. Additional treatments may be required to try to meet your expectations. Please call our office to be seen for follow-up should any of these concerns arise.
- If you develop a droopy eyebrow or eyelid, do not be alarmed. This uncommon side effect is not serious. You should call our office, as there are eye drops that can be prescribed which will alleviate this problem. This problem generally resolves in several weeks to several months.

If you experience any signs or symptoms that you are concerned about please do not hesitate to call Debbie Evans, Cape Aesthetics at 573-225-2442.

Cape Aesthetics

BOTOX® COSMETIC: PATIENT INFORMATION

BOTOX® (botulinum A toxin) has been used for nearly two decades in children and adults to improve medical conditions characterized by muscle spasms. BOTOX® cosmetic is FDA approved for the cosmetic treatment of glabellar frown lines (the wrinkles between the eyebrows). In addition, it has been used widely off-label for the successful treatment of other sites including forehead wrinkles, wrinkles around the eyes ("crow's feet"), upper lip wrinkles, chin, neck and nose ("bunny lines").

Injection of minute amounts of BOTOX® cosmetic into small muscles of the face and neck cause these muscles to weaken, thereby improving the appearance of the overlying wrinkles, preventing frowning, and resulting in a softer, smoother appearance of the overlying skin.

Treatment Results:

The results of BOTOX® treatment are usually dramatic with high rates of patient satisfaction. Some residual muscle movement is necessary and natural. The goal is not to appear "frozen" but to look rested and relaxed. Visible results typically develop over 3-10 days. There is a gradual weakening of the treated muscles that is maximal at about 2-4 weeks after treatment. Results typically last 3-5 months and can vary from patient to patient. Treatment with BOTOX® is not permanent. Over time, as the material is slowly absorbed, fine lines or wrinkles will reappear. Further treatment may be repeated to maintain correction, if so desired. With continued treatment over time, patients often note that their results tend to last longer. After multiple treatments, a majority of patients come in only twice yearly to maintain improvement.

Most patients are very pleased with their results from BOTOX® injection. However, as with any cosmetic procedure, there is no guarantee that you will be completely satisfied. There is no guarantee that fine lines or wrinkles will disappear completely, or that you will not require additional treatments to achieve the results you seek. Sometimes, the initial correction is just what you wanted but seems to wane quicker than you expected. Other times, the correction is less than what you had hoped for or expected. In either circumstance, additional treatments may be required to try to meet your expectations. Costs for treatment are based upon the amount of BOTOX® injected.

Over time, alterations in face and eyelid appearance may continue to occur as a result of aging, weight loss or gain, sun exposure or other circumstances not related to BOTOX® injections. Although there is some evidence to suggest that continued treatment with BOTOX® may help to prevent the development or deepening of fine lines and wrinkles, BOTOX® does not arrest the aging process.

Risks and Complications:

Complications and side effects from BOTOX® are generally mild and transient. Most people have lightly swollen pinkish bumps at the sites of injection, which generally last for a few hours or less. Other potential side effects include bruising, numbness, irritation, or tenderness at an injection site, and headache. Rarely, an adjacent muscle may be weakened following an injection. This may cause double vision or difficulty in raising the eyelid or eyebrow. This complication can last several weeks or longer and occurs in less that 3% of treatments. If this complication occurs, eye drops can be prescribed to minimize the effect. In a very small number of individuals, the injection is not as effective as expected.

As everyone has slight differences in facial musculature, there may 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 with additional treatment. However, in rare instances, this appearance can persist for several weeks or months. Several treatment sessions may be needed to obtain desired results. Rarely, uncommon reactions have been reported such as headache, flu-like symptoms with mild fever, respiratory problems such as sinusitis and bronchitis, dizziness, nausea, infection, nerve damage and allergic reaction.

Cape Aesthetics

Injectable Fillers (Juvederm™/Radiesse™)
Pre and Post-Care Instructions

1. Your first appointment will be for discussing your aesthetic goals and options, treatment will be scheduled separately.
2. Cape Aesthetics only uses FDA approved injectable fillers Juvederm™ or Radiesse™.
3. Prior to injection, please notify us if you have a rash or infection near or at the planned injection site as we will need to reschedule your treatment.
4. 5-7 days prior to treatment avoid blood thinning agents such as Aspirin, Motrin, Aleve or alcohol. Tylenol is OK to use. Please notify us if you are using prescription or non-prescription blood thinners. Bruising is most common around the eyes. We make every effort to avoid bruising, but, there are several small vessels in this area. Bruising is usually minimal and may take around 2 weeks to resolve. Please avoid caffeine the day of the procedure for more comfort.
5. Injectable fillers are present immediately, but will take 1-2 weeks to "settle". ***Since everybody is different, your treatment is tailored specifically for you. We would like to see you back in 2 weeks for a quick check of your treatment outcome.*** Sometimes it can be difficult to match expectations with results, but we will strive to accurately inform you of what to expect. We appreciate your trust in us.
6. If you would like to reapply makeup, please do so gently over the treated area. Do not wear a baseball cap or hat for 24 hours if the forehead was treated. Please avoid heavy exercise or sweating for the first 24 hours after treatment and also avoid any compression of the area. (No swimming goggles after an injectable filler treatment of the cheeks or tear troughs).
7. There are several other treatments and products available if you have aesthetic goals that you haven't met, ask your provider what other treatments may be right for you.
8. Product trials, as well as our own patient experiences, report average duration of results is approximately 1 year to 18 months. Regular injection intervals maintain an optimal aesthetic result and prevent returning to your original pre-treatment condition.
9. Let us know if you have any comments, questions or concerns. The staff at Cape Aesthetics is committed to patient education, safety and care. Contact us with any questions or concerns.