MICHELE MACLEAN, M.D.

Cosmetic Medicine Health History

Name _____ **DOB**_____

Address _____

Cell _____ **Home** _____ **MSI**_____ **Exp Date**_____

Email _____ **Emerg Contact Name/Phone** _____

Family Physician _____

Do you have:

□ Cold sores/herpes _____if so, do you have access to Antiviral Medication _____
□ Special event in the next 2 weeks _____
□ Active infection _____ Antibiotics _____
□ Fainting history _____
□ Needle phobia (tell us as we can help you) _____
□ Recent or planned dental work in a 2-4 week time span _____
□ Accutane in the past 6 months _____
□ Sinus/Rhinitis infection _____
□ Skin Disease /Keloid _____
□ Bleeding disorders _____
□ HIV or Hepatitis _____
□ Allergy to Yellow Jacket Bees _____
□ Eye issues including lid drop _____
□ Body Dysmorphic Disorder or OCD _____
□ Diabetes _____
□ Steroid Therapy _____
□ Autoimmune disorder (Lupus, RA, Thyroid) _____
□ Neurological - ALS, MS, Parkinson's Dz, Myasthenia Gravis, Seizures, Numbness, Muscle Weakness_____
□ Hypertension (High Blood Pressure not under control) _____

□ Hormonal imbalance/Therapy _____

□ Kidney Disease _____

□ Cancer/Chemo/Radiation _____

□ Orthopedic implants _____

□ Pacemaker/Defibrillator _____

□ Anything else you think relevant to your care _____

□ Previous surgeries Face/Neck/ Dental_____

□ List Prescription Meds _____

□ List OTC/Herbal Meds _____

□ Allergies _____Anaphylaxis (severe allergy)_____

□ Pregnant _____ Trying in the next 6 mos _____ Not sure _____

□ Breastfeeding _____

□ Prior Botulinum_____ Last tx ____ Satisfied? If not, why _____

□ Prior Filler _____ Where/When _____

Satisfied? _____

Please be accurate so we can keep you safe. Advise us if changes occur in your health. I acknowledge I read, understood and answered the medical history truthfully.

Patient Signature _____

MD Signature _____

RN Signature _____

I am interested in:
Botulinum Neuromodulator_____

Fillers _____

Hyperhydrosis (Excessive sweating) _____

Skin tags _____

Sun Spots _____

Age Spots _____

Skin Care Advice / Products _____

BOTULINUM NEUROMODULATOR PATIENT CONSENT FORM

- **I authorize _____ to perform Botulinum treatments** to reduce the appearance of my facial wrinkles in the areas treated. I understand that Botulinum relaxes the muscles under my skin, reducing the wrinkling caused by muscular contraction. I understand that tiny amounts of Botulinum will be injected into the muscles under my skin and will temporarily cause my muscles to relax for approximately three to four months. Although results are commonly predictable and provide a good outcome, I have been informed that medicine is not an exact science and that no guarantees can be made concerning expected results in my case.

- **I also understand that it can take up to 14 days** for the total result to occur, although the benefits may begin to develop within the first 3-4 days. I understand that the areas treated will reduce muscle movement and that there is no guarantee that wrinkles will be erased entirely. I understand that the lines directly under the eyes are not affected.

- **I understand that side effects or complications are rare and are not permanent.** Occasionally, slight swelling and/or bruising may occur for several days after the injections and transient headaches. Rarely, an adjacent muscle may be weakened for several weeks after the treatment. There is less than a 1% chance of upper eyelid weakness, which means the top eyelid could droop for several weeks. The droop always resolves. For off label sites that we do which may include browlift , bunny lines nose, lipflip and barcode lines , DAO'S that pull down the corner of the mouth , mentalis that causes the orange peel appearance of the lower chin , the platysma that pulls down the skin at the jawline , the neck bands , masseter reduction , there are numerous benefits but potential harms can include asymmetry (temporary), dropped or crooked smile (think Popeye) , neck weakness or difficulty with speech and swallowing (with higher doses than we traditionally use) .

- **I received a Botulinum Post Treatment Instruction** form and agree to follow the recommendations.

- **Photographs.** I authorize the taking of clinical photographs for my clinical record.

- **Payment**. I understand this is a cosmetic procedure, and payment is my responsibility.

I agree this constitutes full disclosure. I have read and fully understand the above paragraphs and have had sufficient opportunity to discuss and ask questions. I accept the risks and complications of the procedure.

PRINT Patient Name: _____

Patient Signature: _____

Date: _____

PRINT MD/RN Name: _____

MD/RN Signature: _____

Date: _____

Botulinum Neuromodulator Post-Treatment Instructions

- No Lying down for 4 hours
- No Hats or Headbands for 24 hours
- No vigorous exercise for 1 day
- When washing face first day, gently move upward in direction
- No facial treatments for the next 2 weeks
- Avoid wearing makeup where the injections were for the first day if able
- No massage in a donut ring for the next 2 weeks
- Botulinum (myomodulators) start to work in 2 days and peak at 14 days
- Botulinum lasts 3-4 months and usually has a slow wean in and a slow wean out
- Any asymmetry that may happen is best managed at the 2 week interval rather than earlier to ensure all the muscle fibres have been relaxed. Call us to discuss.
- Minimal bruising, mild headache can occur. Tylenol can be tried if not allergic to it.
- Eyebrow and lid ptosis, double vision can occur. These events are not permanent but are distressing. They can last about 4 weeks (variable). Eye drops for lid drop can be prescribed if this happens. Call us if you have this happen so we can discuss and manage it with you. Be kind to your injector - these are often related to your variation in human anatomy and are not related to our technique. Be mindful to not rub product into the eye after injection especially in the first 24 hours.
- Call if you experience something you are concerned about. I would appreciate a picture sent to me.

Hope you are happy with your treatment!

Dr. Michele MacLean 902-430-0990

Consent to Use Electronic Communications

Michele MacLean, M.D.
drmml2001@gmail.com
902-430-0990
www.michelemacleanmd.com

Dr. MacLean has offered to communicate using the following means of electronic communication the services [check all that apply]:

Email _____

Text _____

Video conferencing (Webex, Teams) _____

Social media _____

Website _____

Client Acknowledge and Agreement:

I acknowledge that I have read and fully understand the risks, limitations, conditions of use, and instructions for use of the selected electronic communication.

I acknowledge and understand that despite recommendations that encryption software be used as a security mechanism for electronic communications, it is possible that communications with the Physician or the Physician's staff using the Services may not be encrypted. Despite this, I agree to communicate with the Physician or the Physician's staff using these Services with a full understanding of the risk.

I acknowledge that either I or Dr. MacLean may, at any time, withdraw the option of communicating electronically through the Services upon providing written notice. Any questions I had have been answered.

Name: _____

Address: _____

Phone: _____

Email: _____

Client Signature: _____ **Date:** _____

Witness Signature: _____ **Date:** _____