The Women's Group of Northwestern
OBSTETRICS AND GYNECOLOGY
www.womenobgyn.net

PATIENT INFORMATION AND MEDICAL HISTORY

Name. _____ Date: _____

Address_____ City_____ State_____ Zip _____

Home Phone _____Work Phone: _____ E-mail Address_____

Date of Birth_____ Age _____ Sex_____

HISTORY

Please check if you have had the following:

Diabetes _____

Hepatitis _____

Herpes _____

Irregular menses _____

Heart problems _____

Hypertension _____

Photosensitive Disorder _____

Autoimmune illness _____

Are you under the care of a physician? _____

Current/Recent medications _____

_____

		If yes explain
Keloid scars	Yes	No _____
Hives	Yes	No _____
Skin Cancer	Yes	No _____
Waxing	Yes	No _____
Electrolysis Cold Sores	Yes	No _____
Hypersensitivity to skin products	Yes	No _____
Skin Infections	Yes	No _____
Tanning within the last 6 wks	Yes	No _____
Use of acne products/drugs	Yes	No _____
Laser skin resurfacing Chemical Peels	Yes	No _____
Photo sensitizing substances	Yes	No _____
Laser work of any type	Yes	No _____

Medical Illness. _____

Are you pregnant? _____

Allergies of any kind including drugs_____

Areas of interest for aesthetic treatment _____

Requested Area of Treatment:

BOTOX

Frown lines (between the eyes) _____

Horizontal forehead lines_____

Crow's Feet_____

Bunny lines (bridge of nose}_____

Droopy Eyebrow _____

Filler

Lip Augmentation. _____

Nasolabial folds. _____

Marionette Lines. _____

Vertical Lip Lines_____

Scar fill-in _____

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THE WOMEN'S GROUP OF NORTHWESTERN
312.440.3810 Chicago /847.291.3992 Northbrook

PATIENT _____ **Date:**_____

DATE OF BIRTH _____ **EMR #:** _____

ADDRESS _____ **PHONE:** _____

The purpose of this informed consent form is to provide written information regarding the risks, benefits and alternatives of the procedure named above. This material serves as a supplement to the discussion you have with your doctor/healthcare provider. It is important that you fully understand this information, so please read this document thoroughly. If you have any questions regarding the procedure, ask your doctor/healthcare professional prior to signing the consent form.

THE TREATMENT

Treatment with dermal fillers (such as Juvederm, products, Voluma, Vollure, XC Ultra & Ultra Plus, Vobella) can smooth out facial folds and wrinkles, add volume to the lips, and contour facial features that have lost their volume and fullness due to aging, sun exposure, illness, etc. Facial rejuvenation can be carried out with minimal complications. These dermal fillers are injected under the skin with a very fine needle. This produces natural appearing volume under wrinkles and folds which are lifted up and smoothed out. The results can often be seen immediately but my expand within 1-4 weeks to final fullness effect. **Initial ____**

RISKS AND COMPLICATIONS

Before undergoing this procedure, understanding the risks is essential. No procedure is completely risk-free. The following risks may occur, but there may be unforeseen risks and risks that are not included on this list. Some of these risks, if they occur, may necessitate hospitalization, and/or extended outpatient therapy to permit adequate treatment. It has been explained to me that there are certain inherent and potential risks and side effects in any invasive procedure and in this specific instance such risks include but are not limited to: 1) Post treatment discomfort, swelling, redness, bruising, and discoloration; 2) Post treatment infection associated with any transcutaneous (skin) injection; 3) Allergic reaction; 4) Reactivation of herpes (cold sores); 5) Lumpiness, visible yellow or white patches; 6) Granuloma formation; 7) Localized necrosis and/or sloughing, with scab and/or without scab if blood vessel occlusion occurs. **Initial ____**

PREGNANCY AND ALLERGIES

I am not aware that I am pregnant. I am not trying to get pregnant. I am not lactating (nursing). I do not have or have not had any major illnesses which would prohibit me from receiving dermal fillers. I certify that I do not have multiple allergies or high sensitivity to medications, including but not limited to lidocaine. **Initial ____**

ALTERNATIVE PROCEDURES

Alternatives to the procedures and options that I have volunteered for have been fully explained to me.
Initial ____

PAYMENT
I understand that this is an "elective" procedure and that payment is my responsibility and is expected at the time of treatment. **Initial ____**

RIGHT TO DISCONTINUE TREATMENT
I understand that I have the right to discontinue treatment at any time. **Initial ____**

PHOTOGRAPHY MATERIALS
I authorize the taking of clinical photographs and videos and their use for scientific and marketing purposes before and after treatments.
Initial ____

RESULTS
Dermal fillers have been shown to be safe and effective when compared to collagen skin implants and related products to fill in wrinkles, lines and folds in the skin on the face. Their effect can last up to 12-18 months. Most patients are pleased with the results of dermal fillers use. However, like any esthetic procedure, there is no guarantee that you will be completely satisfied. There is no guarantee that wrinkles and folds will disappear completely, or that you will not require additional treatment to achieve the results you seek. The dermal filler procedure is temporary and additional treatments will be required periodically, generally within 4-6 months, involving additional injections for the effect to continue. I am aware that follow-up treatments will be needed to maintain the full effects. I am aware the duration of treatment is dependent on many factors including but not limited to: age, sex, tissue conditions, my general health and life style conditions, and sun exposure. The correction, depending on these factors, may last up to 12 months and in some cases shorter and some cases longer. I have been instructed in and understand the post-treatment instructions. **Initial ____**

I understand this is an elective procedure and I hereby voluntarily consent to treatment with dermal fillers for facial rejuvenation, lip enhancement, establish proper lip and smile lines, and replacing facial volume. The procedure has been fully explained to me. I also understand that any treatment performed is between me and the doctor/healthcare provider who is treating me and I will direct all post-operative questions or concerns to the treating clinician. I have read the above and understand it. My questions have been answered satisfactorily. I accept the risks and complications of the procedure and I understand that no guarantees are implied as to the outcome of the procedure. I also certify that if I have any changes in my medical history I will notify the doctor/healthcare professional who treated me immediately. I also state that I read and write in English.

_____

Patient Name (Print) Patient Signature Date

I am the treating doctor/healthcare professional. I discussed the above risks, benefits, and alternatives with the patient. The patient had an opportunity to have all questions answered and was offered a copy of this informed consent. The patient has been told to contact my office should they have any questions or concerns after this treatment procedure.

_____

Doctor Name (Print) Doctor Signature Date

Medical Records Number: _____

Date: _____ Patient Name: _____

Patient Treatment Chart for Botox & Filler

Injection pattern

___ Photos (before)

__ BOTOX

LOT NUMBER#_____

Areas Treated	Units Used
1. Glabellar	_____
2. Frontalis	_____
3. Crows Feet	_____
4. _____	_____

Total Areas treated: _____

Total Units used: _____

___ Photos (after)

___ Photos (before)

__ DERMAL FILLER_____

LOT NUMBER#_____

__ DERMAL FILLER_____

LOT NUMBER#_____

Areas Treated	Units Used
1. Parentheses (smile) lines	_____
2. Lip Line	_____
3. Corner Lines	_____
4. Marionette lines	_____
5. Thin Lips	_____

Total Areas treated: _____

Total Units used: _____

___ Photos After

ITEM	UNIT COST	TOTAL FEE
BOTOX	_____	_____
DERMAL FILLER	_____	_____

TOTAL $_____

Patient SignatureX_____ Provider signature _____

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INJECTABLE PRE-INSTRUCTIONS AND INFORMATION

1. To decrease the incidence of bruising and bleeding, refrain from all **blood-thinning medications and supplements 14 days before an injectable filler treatment**. If you need to take something for the relief of minor aches or pains, **YOU MAY TAKE TYLENOL** (Acetaminophen). Please refer to your medication sheet for a comprehensive list. If you have any questions, please call our office, and speak with your provider.

2. Please avoid any alcohol for 48 hours before your injectable treatment.

3. If you tend to bruise easily, begin taking homeopathic Arnica 2 days before treatment (used to reduce bruising and swelling) or Arnica Montana as directed which is found at Whole Foods and Vitamin Stores.

4. Ice Compress are used throughout the procedure for your comfort and to help minimize swelling and bruising.

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Medication/Supplements to Avoid

1-Week Prior to Botox Treatment AND 2 Weeks Prior to an injectable Filler Treatment

Advil
Aleve
Allegra
Alka-Seltzer
Alka-Seltzer Plus
Anacin
Anaprox
Anadynos
Ansaid
A.P.C.
Argesic
Arthropan Liquid
Arthritis Pain Formula
Arthritis Strength Bufferin
A.S.A.
A.S.A. Enseals
Ascriptin
Ascriptin A/D
Ascriptin w/Codine
Ascriptin Extra Strength
Asperbuf
Aspergum
Aspirin
Atromid
Axotal
Axolid
Bayer Aspirin
Bayer Aspirin Maximum
Bayer Children's Aspirin
Bayer Children's Cold
Bayer Time-Release
B.C. Tablets and Powder
Buff-a-Comp
Buff-a-Comp No. 3
Buffets II
Buffinol
Buf-Tabs
Butazolidin
Cams Arthritis Pain Reliever
Carisoprodol
Celebrex
Cheracol Capsules
Chlortrimeton
Clinoril
Congesprin Chewable
Cope Tablets
Coumadin
CP-2 Tablets
Damason-P
Darvon Compound
Darvon Compound-65
Darvon N with A.S.A.
Darvon w/A.S.A.
Pulvules
Di-gesic
Disalcid
Dolobid
Dolprin
Dristan
Durasal Tablets
Easprin
Ecotin
Efficin
Elavil
Emagrin
Emprazil
Empirin with Codeine
Encaprin
Endep
Equagesic Tablets
Etrafon
Excedrin
Feldene
Florinal
Flagyl
Flexeril
Four-Way Cold Tablets
Gaysal-S
Gelprin
Gemnisin
Goody's
Heparin
Ibuprofen
Indocin
Indomethacin
Ianorinal
Lioresal
Lortab
Lovenox
Magan
Magsal
Marnal
Maximum Bayer Aspirin
Measurin
Medomem
Methcarbamol w/Aspirin
Micrainin
Mobidin
Midol
Mobigesic
Momentum Muscular
Backache Formula
Motrin
Mysteclin F
Nalfon
Naprosyn
Neocylate
Nicobid
Norgesic
Norgesic Forte
Nuprin
Oraflex
Orudis
Pabalate-SF
Pamelor
Parnate
Pepto-Bismol Tablets
Pepto-Bismol Suspension
Percodan
Persantine
Persistin
Phentermine
Phenylbutazone
Pontel
Propoxyphene Compound 65
Robaxisal
Rufen
Ru-Tuss
S.A.C.
Saleto
Salocal
Sine Aid
Sine-off Sinus Medicine
Sinutab
SK-65 Compound
Stanback
Stendin
St. Joseph's Aspirin for Kids
St. Joseph's Cold Tablets
Sulindac
Surmontil
Synalgos
Tagamet
Talwin Compound
Tenuate Dospan
Tetracycline
Tolectin
Tometin
Triaminicin
Triavil
Trigesic
Trilisate Tablets & Liquids
Tumeric
Uracel
Vanquis
Verin
Vibramycin
Voltaren
Wine/Alcohol
Zomax
Zorprin

HERBAL SUPPLEMENTS

Billberry (vaccinum myrtilllus)
Cumin
Feverfew (tanacetum paithenium)
Garlic (allium sativum)
Ginseng (panax ginseng/panax quinquefolium)
Licorice Root (gylcyrrhiza glabra)
Red Clover (trifolium pretense)
Vitamin E
Cayenne (capsicum annuum)
Dong QuaL (angelica alnensis)
Fish Oil (Omega 3)
Ginger (zingiber officinate)
Hawthorne (crataegus laevigata)
Ma Huang (ephedra sinica)
St. John's Wart (hypericum peforatum)
Yohimbe (corynanthe yohimbe)
Chia Seeds
Echinacea (Echinacea augusifolia)
Flax Seed
Ginko Biloba
Kava Kava (piper methysticum)
Melatonin
Valerian (valerian officinalis)

- *Any questions on Medication/Supplements to avoid, please call your provider.*

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