

Mesotherapy Treatment Record

Patient Name: _____ Date: ___/___/___ Time: _____

Physician: _____ Nurse: _____

Allergies: _____

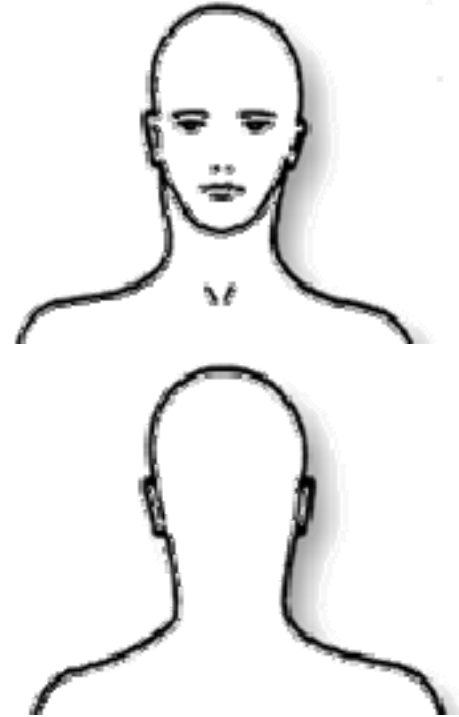
Procedure: _____

Treatment Number: _____

Topical Anesthesia: _____

Skin Prep: _____

Notes: _____



MEDICATION						
Syringe 1	c.c	c.c	c.c	c.c	c.c	c.c
Syringe 2	c.c	c.c	c.c	c.c	c.c	c.c
Syringe 3	c.c	c.c	c.c	c.c	c.c	c.c
Syringe 4	c.c	c.c	c.c	c.c	c.c	c.c
Syringe 5	c.c	c.c	c.c	c.c	c.c	c.c

AREAS					
Amount Used	c.c	c.c	c.c	c.c	c.c

Total ml Used: _____

Follow Up Procedure Due: _____

Notes: _____

