PATIENT INFORMATION AND MEDICAL HISTORY

Name_____

Address_____City_____ State_____ Zip_____

Phone_____ E-mail Address_____

Date of Birth_____ Age_____

HISTORY

Please check if you have or have had –

Anaphylaxis	_____	Multiple Severe Allergies	_____
Bleeding problems	_____	Prior reaction to aesthetic treatment	_____
Connective Tissue disease	_____	Heart problems	_____
Herpes / Cold Sores	_____	Breathing Problems	_____
Swallowing problems	_____	Drooping eyelids	_____
Forehead muscle weakness	_____	Weakness of your forehead muscles	_____
Keloid scars	_____	Autoimmune illness	_____
Recurrent hives	_____	Current skin infection	_____

Conditions affecting muscles or nerves (such as ALS, Myasthenia gravis, lambert-easton syndrome) _____

For hyperhidrosis, have you had evaluation for causes of the condition by your PCP? _____

IF YES, EXPLAIN

Any surgery on your face	Yes	No	_____
Any botulinum toxin treatment (in last 4 months)	Yes	No	_____
Skin Cancer	Yes	No	_____
Any cosmetic treatment in the last 4 weeks	Yes	No	_____
Problems with dry eyes	Yes	No	_____
Any acute or chronic skin disease	Yes	No	_____
Plans to have surgery	Yes	No	_____
Any antibiotic in the last 7 days	Yes	No	_____
Any aspirin containing product in the last 7 days	Yes	No	_____
Any blood thinner type medication	Yes	No	_____
Use of St. John's Wort, Vitamin E or fish oil?	Yes	No	_____
Any muscle relaxer type medication	Yes	No	_____
Any allergy or cold medicine	Yes	No	_____
Any sleep medicine	Yes	No	_____
MAOI or TCA type antidepressant medications	Yes	No	_____

Are you pregnant, planning to become pregnant or currently breastfeeding?_____

Allergies of any kind including drugs_____

Areas of interest for aesthetic treatment_____

Requested Area of Treatment:

Neurotoxin

Frown lines (between the eyes)_____
Horizontal forehead lines_____
Crow's Feet_____
Bunny lines (bridge of nose)_____

Dermal Filler

Lip Augmentation_____
Nasolabial folds_____
Marionette Lines_____
Vertical lip lines_____

Microneedling

Facial treatment _____
Other location _____

PDO Thread Lifts

Area to be treated _____

I ATTEST THE ABOVE INFORMATION TO BE TRUE, KNOWING MY PROVIDER RELIES ON THIS INFORMATION TO PROVIDE SAFE AND EFFECTIVE TREATMENT.

Patient Signature_____ Date _____