BOTOX / DERMAL FILLER
CLIENT INFORMATION & MEDICAL HISTORY

In order to provide you with the most appropriate treatment, please complete the following questionnaire. *All information is strictly confidential.*

PERSONAL HISTORY

Name: _____ Today's date: _____

Date of Birth _____ Age _____ Occupation _____

Home address _____City _____State ____ Zip_____

Phone/Home _____Work _____Cell_____

Email address _____

Emergency Contact _____Phone _____

How were you referred to us? _____

Do you regularly sun bathe or use tanning salons? _____ Yes _____No How often?_____

MEDICAL HISTORY

Are you currently under the care of a physician? ____ Yes ____ No

If yes, for what: _____

_____

Do you have any of the following medical conditions? ***Please check all that apply***

____ Cancer	____ Diabetes	____ High blood pressure
____ Herpes	____ Arthritis	____ HIV/AIDS
____ Frequent cold sores	____ Keloid scarring	____ Skin disease / skin lesions
____ Seizure disorder	____ Hepatitis / Type ____	____ Hormone imbalance
____ Thyroid imbalance	____ Blood clotting abnormalities	____ Any active infection

Do you have any other health problems or medical conditions? Please list: _____

_____

Have you ever had an allergic reaction? (List any and all that you have had and describe the reaction you experienced)

____ Food	____ Animal Protein	____ Aspirin
____ Lidocaine	____ Hydrocortisone	____ Hydroquinone
____ Skin Bleaching agents		

Reaction: _____

_____

_____

MEDICATIONS

What oral prescription medications are you presently taking:

____ Birth control pills ____ Hormones

____ Others (It is required that you list all of them): _____

_____

What antibiotics do you use to treat infections? _____

_____

Do you take any medications for heart conditions? _____

_____

Are you taking any mood altering or anti-depression medication? ____ Yes ____ No

If yes / what? _____

What topical medications or creams are you currently using?

____ Retin A ____ Others / Please list: _____

_____

What herbal supplements do you use regularly? _____

_____

HISTORY

For our female clients:

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

Are you breast feeding? ____ Yes ____ No

Are you using contraception? ____ Yes ____ No

I certify that the preceding medical, medication and personal history statements are true and correct. I am aware that it is my responsibility to inform the doctor or other health professional of my current medical or health conditions and to update this history as needed. A current medical history is essential for the Doctor to execute appropriate treatment procedures.

Signature _____ Date _____