Medical History Form

Name_____ Date_____

Address_____ City_____ State_____ Zip_____

Mobile Phone _____ Work Phone _____

Home Phone _____ Email _____

Date of Birth _____ Sex Male Female Transgender Prefer to not answer

You may contact me at (check all that apply) Mobile Work Home Email

You may leave a detailed message at (check all that apply) Mobile Work Home Email

Who should we contact in case of emergency? _____

Relationship _____ Phone Number _____

How did you hear about our practice? _____

Who may we thank for referring you? _____

What are your concerns? Please check all that apply.

Forehead Lines	Lip Appearance & Texture	Skin appearance and texture
Frown Lines	Thin Lips	Excessive underarm sweating
Crow's Feet Lines	Double Chin	Other (please specify)
Flattened/Sunken Cheeks	Jawline Appearance	_____
Lines/wrinkles around the nose and mouth	Lip Appearance & Texture	_____
		_____
		_____

How long have you noticed this problem? _____

Prior treatments (if any) _____

_____

_____

Have you had Aesthetic injections before? Yes No Botox Dysport Xeomin Jeuveau

If so, when was your last treatment and areas treated? _____

Have you had Dermal Filler injections before? Yes No Juvederm Restalyne Belotero

If so, when was your last treatment and areas treated? _____

Have you had injections of? Radiesse Sculptra Bellafill

If so, when was your last treatment and areas treated? _____

Please list all current medications that you are currently or occasionally taking (prescription and over-the counter) _____

_____

_____

Do you have any known drug allergies: Yes No

If yes, please describe: _____

_____

Have you ever had ANY reaction to Novacaine, Xylocaine, Lidocaine, Epinephrine? Yes No

If yes, please describe: _____

_____

Past Medical History

Have you ever had: (please ✓ all that apply)

Hepatitis/HIV	High Blood pressure	Cold Sores
Liver or Kidney Problems	Heat Disease	Stroke
Diabetes	Irregular Heart Beat	Glaucoma
Asthma	Rheumatic Fever	Irregular Vision
Autoimmune Disorders	Thyroid Disease	Blood Disorders

Other medical problems: _____

_____

_____

_____

Please list past surgical procedures:

_____

_____

_____

_____

Do you smoke or use tobacco products?	Yes	No
If yes, how many cigarettes per day? _____		
Do you consume alcohol?	Yes	No
If yes, how many drinks per day? _____		
Have you ever had a reaction to dermal filler before?	Yes	No
Have you ever had problems healing after a procedure?	Yes	No
Do you have a history of raised scars or keloids?	Yes	No
Have you had dental work (cleaning, procedures) within the past 2 weeks?	Yes	No

Patient Signature: _____ Date: _____

Provider Signature: _____ Date: _____