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_________ 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):

____
____

Do you take any blood thinning medications (NSAIDs, aspirin, warfarin)?

____
____

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 ________________________