Health History
Dermal Filler/Botox Injections

Name: ______________________________ DOB: ______________
Please Print

Address: ______________________________
Street City State/Zip

Phone: ______________________ ______________________
Cell Phone *Home Phone*

Email: ______________________________
Would you like to receive emails about our specials Yes No

Emergency Contact Name/Relationship: ______________________ Phone: ______________

How did you hear about us: ______________________________

1. Are you currently being treated for any medical conditions: ______________________________

2. Please list ALL allergies you may have (medications, food, pollen, etc.) and briefly describe your reaction (i.e. rash, hives, shortness of breath, etc.); if no allergies, please write "NONE": ______________________________

3. Please list any medications (include dosage), including prescription and over-the-counter medicines, topical creams, facial skin care products and medicinal herbs you use: ______________________________

Please answer the following:

Please answer the following:	Complications from any cosmetic procedure?	Yes	No
	Form thick or raised scars from cuts or burns?	Yes	No
	Any active infection?	Yes	No
	Are you pregnant?	Yes	No
	Any history of cold sores in the treatment area?	Yes	No

I certify that the preceding information is thorough and accurate to the best of my knowledge. I am aware that it is my responsibility to inform the staff members of any current medical and health conditions and to update this history.

I also confirm that I received clarification on my questions.

Signature: ______________________________ Date: ______________

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