



**PATIENT INFORMATION AND MEDICAL HISTORY**

Name \_\_\_\_\_ Date \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_  
E-mail Address \_\_\_\_\_  
Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ Sex \_\_\_\_\_

**HISTORY**

**Please check if you have or have had:**

Diabetes    Irregular menses    Hepatitis    Heart problems    Herpes  
Hysterectomy    Menopause    Hypertension    Sensitive to anesthetic  
Photosensitive Disorder    Lupus    Autoimmune illness  
Are you under the care of a physician?  
If so, physician name: \_\_\_\_\_

**Current/Recent medications:**

**IF YES, EXPLAIN:**

Keloid scars  
Hives  
Skin Cancer  
Waxing  
Electrolysis  
Cold Sores  
Hypersensitivity to skin products  
Skin Infections  
Tanning within the last 6 wks  
Use of acne products/drugs  
Laser skin resurfacing  
Chemical Peels  
Photo sensitizing substances  
Laser work of any type  
Medical Illness  
Are you pregnant?



Allergies of any kind including drugs:

Areas of interest for aesthetic treatment:

Requested Area of Treatment:

**Do not fill anything beyond this point: PROVIDER ONLY**

**BOTOX Filler**

Frown lines (between the eyes)

Lip Augmentation

Horizontal forehead lines

Nasolabial folds

Crow's Feet

Marionette Lines

Bunny lines (bridge of nose)

Vertical lip lines

Droopy Eyebrow

Scar fill-in

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

Patient Signature

Date