BOTOX AND FILLER HEALTH FORM

NAME:_____ Date:_____

DATE OF BIRTH:_____ AGE:_____ SEX:_____

ADDRESS:_____

CITY:_____ STATE:_____ ZIP:_____

EMAIL:_____ PHONE:_____

HOW DID YOU HEAR ABOUT US:_____

LIST ANY CONDITION YOU ARE CURRENTLY BEING TREATED FOR OR HAVE A HISTORY OF:

_____

_____

_____

Do you have history of: LIDOCAINE ALLERGY or ANAPHYLAXIS _____ yes or no

MEDICATION ALLERGIES:

_____

MEDICATIONS: PLEASE INCLUDE TOPICAL, OVER THE COUNTER, HEBAL/HOLISTIC REMEDIES & SUPPLEMENTS AND PRESCRIPTIONS:

_____

Circle any used within the last 7 days:

Aspirin Ibuprofen Motrin Warfarin/blood thinners Fish oil

Ginkgo Vitamin E Antibiotics Retinol or Retin-A Vitamin A

Hydroquinone Accutane

History of tanning bed use**: YES NO** If so, has it been in the last 4 weeks: **YES NO**

Do you see a dermatologist: **YES NO** Who?_____ Date last seen_____

List any plastic surgery in your past:_____

Do you get cold sores: **YES NO** **Keloid scaring: YES NO** **Staph infections: YES NO**

Have you had botulinum toxin injections before? **YES NO** Date of last treatment: _____

Have you ever had dermal filler injections? **YES NO** Date of last treatment: _____

Model Agreement: I agree to allow JHA to use Before and After photos on the website and/or social media. (Initial one)

_____ ***Full face***

_____ ***Individual Area***

_____ ***No Permission***

FOR FEMALE PATIENTS:

Are you currently pregnant or plan to become pregnant: **YES NO**

Are you currently lactating? **YES NO**

Do you use birth control? **YES NO** Last menstrual cycle**:** _____

SKINCARE:

Have you ever had a facial treatment before? _____

Do you burn easily? **YES NO** What skincare products do you use:_____

Do you have any special problems or concerns pertaining to your face or body? **YES NO**

If so, please specify _____

Have you ever had chemical peels, microdermabrasion, or laser treatments? **YES NO**

If so, in the last month? _____

_____ _____ _____

Patient Signature **Clinician Signature** **Date**

Notes:_____