Health History Form

Name_____ DOB_____ Age_____

Address_____City/State/Zip_____

Phone_____ Email_____

Primary Physician's Name_____

Please list all medications you are currently taking: _____

Allergies: _____ Are you on Antibiotics at this time? _____
Have you had Botox/Dysport//Xeomin) **Y N**
Have you had Dermal Fillers? (Restylane/Perlane/Juvederm/Collagen/Sculptra/Radiesse) **Y N**
Have you had surgical implants placed in the lips or face? **Y N** If Yes, last treatment date? _____
What areas? _____Complications? _____

Do you have a history of any of the following?

CONTRAINDICATION	CAUTIONS
Y N Under the age of 18	**Y N** Allergy to Visine (Benzyl alcohol)
Y N Currently Pregnant/Breastfeeding	**Y N** Bell's Palsy
Y N Inflammation at the injection site	**Y N** Trigeminal Neuralgia
Y N Allergy to Human Albumin	**Y N** Vision Problems
Y N Allergy to Lidocaine (Dermal Fillers/TAC)	**Y N** Numbness or muscle weakness of the face
Y N Allergy to cow's milk protein (Dysport)	**Y N** Droopy/Sagging/Excess skin of eyelids
Y N Allergy to Gram + Bacteria	**Y N** History of Peri-Oral herpes (cold sores)
Y N Swallowing or Breathing Problems	**Y N** History of Anti-Coagulants/blood thinners
Y N History of anaphylaxis or shock	**Y N** Recent anti-biotic injection
Y N History or presence of severe allergies	**Y N** Muscle relaxants, allergy/cold medicine
Y N History of presence of severe allergies	**Y N** Currently sunburned/irritated/rash on skin
Y N Neurological Disorders (Myasthenia Gravis, ALS-Lou Gehrig's disease, MS, Parkinson's disease, Lambert-Eaton Syndrome)	**Y N** Recent use of Retin A in past 2-3 days
	Y N Use of immunosuppressant
	Y N Autoimmune disease
	Y N History of bleeding disorder

List/Explain other medical conditions not listed above: _____

Signature: _____ Date: _____

Treatment Providers Signature: _____ Date: _____