Dermal Filler Patient History

Name: _____ Date: _____

Address: _____

Telephone: _____ Cell: _____

Date of Birth: _____

Consent signed: Yes No Date: _____

Previous Dermal Filler Yes No Date: _____

Complications: Yes No Date: _____

Type Dermal Fillers: _____

History of Anaphylactic Shock: Yes No Date: _____

History of Allergies: Yes No Date: _____

Medications

Asprin Yes No

Anti-Inflammatories Yes No

Anticoagulants Yes No

Steroids Yes No

Non-Steroidals Yes No
(i.e. Advil, Aleve, Celebrex)

_____

_____

Supplements

Ginko Biloba Yes No

Vitamin A Yes No

Vitamin E Yes No

Garlic Yes No

Flax Oil Yes No

_____

_____

Do you have at present, any history of the following medical conditions?

Have you had in the past, any history of the following medical conditions?

1. Multiple Severe Allergies Yes No
2. HX of Herpes around the Lips Yes No
3. Immunosuppressive Therapy Yes No
4. Autoimmune Disease Yes No
5. Other Medical History Yes No

(if you answered Yes to any one of the above please explain below)

Comments:

_____

_____

_____

_____

_____

I have answered the above questions to the best of my knowledge

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_____ _____

Signature Date