

**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/changes recently |
| **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** Neurological Disorders  (Myasthenia Gravis, ALS-Lou Gehrig’s disease, MS, Parkinson’s  disease, Lambert-Eaton Syndrome) | **Y N** Currently sunburned/irritated/rash on skin |
| **Y** **N** Dental procedures within the past two weeks? | **Y N** Recent use of Retin A in past 2-3 days |
| **Y N** Any Dental procedures in the next two weeks? | **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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**