# DERMAVIS COSMETIC *clinic*

Any known allergies or allergic reactions
to the following? (check the box)

☐Animal Protein ☐Aspirin ☐Hydrocortisone ☐Lidocaine (Anesthetic)
☐Latex. ☐Eggs ☐Bee Sting ☐Hydroquinone or skin ☐bleaching agents
Others allergies: _____

Have you taken any Aspirin, Ibuprofen, Motrin, Tylenol, Fish Oil, Vitamin E, Blood Thinners, and Alcoholic Beverages in the last ten days? (circle) YES or NO If yes, what? _____

**FACIAL HISTORY**

Have you ever had Botox or dermal fillers? (circle) YES or NO
If yes, when were you last treated: _____
Product name: _____
Any complications? (circle) YES or NO
If yes, please specify: _____

**FACIAL INJURY TRAUMA HISTORY**

1) Any history of facial surgery? (circle) YES or NO
Describe: _____

2) Any history of trauma to the head or face? (circle) YES or NO
Describe: _____

Any TMJ problems? (circle) Pain Clenching Grinding

Other medical conditions: _____

Previous Hospitalization/ Operations? _____

Any scheduled dental cleaning or procedures in the next 2 weeks? (circle) YES or NO

Are you leaving the city in the next two weeks? (circle) YES or NO

I understand the information on this form is essential to determine my medical and cosmetic needs and the provision of treatment. I understand that if any changes occur in my medical history/health, I will report it to the clinic as soon as possible. I have read and understood the above medical questionnaire. I acknowledge that all answers have been recorded truthfully and will not hold any staff member responsible for any errors or omissions that I have made in the completion of this form.

_____

**Patient Name (Print)** **Patient Signature** **Date**

I am the treating nurse/healthcare professional. I have reviewed this medical history with the patient and medical director.

_____

**Injector Name (Print)** **Injector Signature** **Date**