SERENITY SKIN SPA, LLC
BOTOX & DERMAL FILLERS NEW CLIENT HISTORY

First Name: ______________________ Last Name: _____________________ DOB: ___________________

Address: _____________________________ City: ________________ State: ______ Zip: _____________

Cell Phone: ________________________

Email Address:

____

List of medications and/or vitamins that you are taking: ____

____

Allergies: ____ Are you taking antibiotics at this time? _________

MEDICAL HISTORY

Yes	No	Myasthenia Gravis
Yes	No	Hepatitis
Yes	No	Eye Disease
Yes	No	Autoimmune Disease
Yes	No	Vision Problems
Yes	No	Numbness

Yes	No	Muscle Weakness
Yes	No	Multiple Sclerosis
Yes	No	Lupus
Yes	No	Parkinson's Disease
Yes	No	Neurological Disorders
Yes	No	Lambert-Eaton Syndrome

Yes	No	History of Cold Sores
Yes	No	Sensitivity/Allergy to Lidocaine
Yes	No	Keloid Formation
Yes	No	Amyotrophic Lateral Sclerosis
Yes	No	Allergy to beef or dairy products
Yes	No	Hypersensitivity to medications

List and/or explain other medical conditions not listed above: ____

____

Previous Hospitalizations/Operations: ____

____

Have you had plastic surgery or other surgery to your face/neck area and when: ___________________________

____

WOMEN: Are you pregnant, trying to get pregnant or lactating? ____

BOTOX /FILLER HISTORY

Have you had Botox/Juvederm injections before? _______________ Last treatment: ___________________

What areas? _________________________________ Were you happy?_________________________

If not, please explain: ____

Have you ever had eyelid/eyebrow droop after Botox? ____

Have you ever had a reaction to fillers that required additional treatment or medical attention? Y / N

____ ____________________

Patient Signature Date

____

Provider Signature