CLIENT INFORMATION & MEDICAL HISTORY

In order to provide you with the most appropriate treatment, please complete the following questionnaire. All information is strictly confidential.

PERSONAL HISTORY

Today's Date_______________

Name________________________Middle Initial__________Date of Birth________________________

Age__________ Occupation____

Home Address____

City______________________________State____________ Zip Code__________________________

Email____(to notify you of specials & events)

Home Phone (_____) ________________________ Cell Phone (_____) __________________________

Employer___________________________________Occupation________________________________

Employer's Address_________________________Phone Number_______________________________

Drivers License State & No____

Emergency Contact Name and Number____

How were you referred to us?____

Treatments of Interest: please check all that apply.

- o Botox/Dysport
- o Dermal Fillers (Restylane, Juvederm, Perlane, Radiesse, Belotero Balance)

BOTULINUM TOXIN "A" AND/OR DERMAL FILLER MEDICAL HISTORY

Are you currently under the care of a physician? ❑Yes ❑ No

If yes, for what:____

____

Primary Physician's Name__________________________Phone Number_________________________

DOB______________________Age____________Ht_______________Wt________________________

Please list all the medications you are currently taking (it is required that you list all of them):__________

____

Are you on any Antibiotics at this time? ______________________ If yes, which ones? ______________

____

List all Vitamin and Herbal Supplements you are currently taking: ____

____

Have you ever had an allergic reaction? (List any and all that you have had and describe the reaction you experienced) ❑Food ❑Animal Protein ❑Aspirin ❑Lidocaine qAntibiotics qOthers:__________________

____

Collagen Tested______________Date_________________Were there complications? __________________________

Check any of the following illnesses you have or have had in the past? (Please check all that apply)

❑Myasthenia Gravis ❑Multiple Severe Allergies/Hypersensitivity to medications ❑Hepatitis

❑Neurological Disorders ❑Lambert-Eaton Syndrome ❑Numbness ❑Keloid Formation

❑Autoimmune Disease ❑Vision Problems ❑Allergies to Human Albumin or Bovine (Cow's Milk)

❑Allergies to Beef/Dairy/Cow's Milk Products ❑Muscle Weakness ❑ History of Cold Sores ❑Lupus

❑Parkinson's Disease ❑Multiple Sclerosis ❑Amyotrophic Lateral Sclerosis (ALS) ❑Eye Disease

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 areas? If Yes, When? ________________________

____

Have you had Botulinum injections and/or Dermal Fillers before? ____

Last Treatment___________________________________ What Area? _______________________________________

Were you happy with previous Botulinum and/or Dermal Filler treatments? ________________________________

Please Explain____

What Dermal Filler was used? ___________________What Area(s)? ____

Botulinum Toxin "A" questions only:

Have you ever had eyelid/eyebrow droop after Botulinum injections? ____
Do you show a lot of upper eyelid when eyes are open? ____
Do your eyelids feel extra heavy when you don't get enough sleep?____
Do your eyelids droop without sleep? ____
Areas of special concern to patient? ____

For our female clients only:

Are you pregnant or trying to become pregnant? ❑Yes ❑No Are you Lactating (nursing)? ❑Yes ❑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 Platinum Aesthetics Mobile MedSpa as soon as possible. I have read and understand the above medical history questionnaire. I acknowledge that all answers have been recorded truthfully and accurately 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 (please print) **Patient Signature** **Date**

Witness Name (please print) **Witness Signature** **Date**