BOTOX & FILLER PATIENT QUESTIONNAIRE

PERSONAL INFORMATION			
First	Middle	Last	Date:
Address:			
Mobile Phone:	Home Phone:	DOB:	Gender: M F

TREATMENT CHECK-IN	
Are you currently under the care of a Health Care Provider? (If yes, please explain.):	
What was your most recent cosmetic treatment? (If this is your first cosmetic treatment, please state so.):	
Person/Company who provided treatment(s)?	Date of Last Treatment:
Have you ever fainted during or immediately following an aesthetic procedure? YES NO	Have you ever had a cosmetic procedure you did not like the outcome of? YES NO
Are you a diabetic? YES NO Are you allergic to Eggs? YES NO Are you allergic to Milk Protein? YES NO Are you allergic to Lidocaine*? YES NO	Do you have any other allergies or can you think of something you've had an adverse reaction to? If yes, please explain.

CURRENT MEDICATION

List any medications that you are taking below. Please include any & all non-prescription (over-the-counter) medications, vitamins & supplements.

NAME (Medication/Vitamin/Supplement)	DOSE (Please include strength / per day)	LENGTH (How long have you been taking this?)
1		
2		
3		
4		
5		
6		

REPRODUCTIVE HISTORY		
Are you currently pregnant? YES NO	Have you been pregnant within the last year? YES NO	Are you currently breastfeeding? YES NO

SKIN HISTORY - Do you have or have you ever had:		
		If yes, please explain (Provide frequency & most recent occurrence):
Keloid Scars	YES NO	
Hives	YES NO	
Skin Cancer	YES NO	
Waxing	YES NO	
Electrolysis	YES NO	
Cold Sores	YES NO	
Hypersensitivity to Skin Products	YES NO	
Skin Infections	YES NO	
Tanning Within the Last 6 Weeks	YES NO	
Use of Acne Products or Drugs	YES NO	
Laser Skin Resurfacing	YES NO	
Chemical Peels	YES NO	
Photo-sensitizing substances (e.g., Antibiotics, Diuretics & Blood Pressure Medication)	YES NO	

Additional information you would like to share related to your health (if any):

Areas of interest for Today's Treatment?

AGREED & SIGNED: I attest the above information to be true, knowing my practitioner(s) rely on this information to provide the most safe and effective treatment.

Patient Name (Print):

Patient Signature: Date:

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