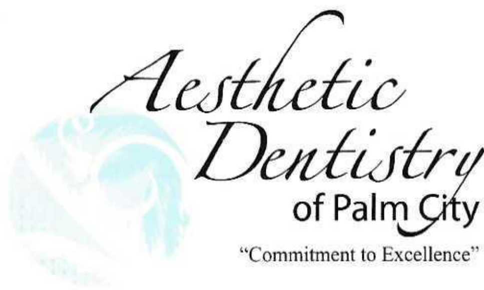

Welcome

MEDICAL HISTORY
DERMAL FILLERS
PDO SOLID FILLERS
PDO THREAD LIFTS

Name ______________________________ Date ____________

Address ______________________________

City ____________________ State __________ Zip __________

Phone ____________________ Email ____________________

Primary Physician ____________________ Phone ____________________

Are you currently taking blood thinners or medications that can interfere with clotting, such as aspirin or Warfarin? ________

Please list all medications and vitamin supplements that you are currently taking. ____________________

____

____

CIRCLE any of the following illnesses you have or have ever had in the past:

Multiple Severe Allergies   Hypersensitivity to Medications   Lupus   Cold Sores

Sensitivity/Allergy to Lidocaine, Sulfa or other ____________________

Autoimmune Disease(s) ____________________

OTHER MEDICAL CONDITIONS not listed above that you currently have or have had in the past:

____

____

Hospitalizations/Operations ____________________

____

WOMEN: Pregnant? Trying to get pregnant? or Lactating (Nursing)? ____________________

Plastic Surgery or other surgery to your face/neck areas & when? ____________________

____

Have you had any Dermal Filler procedures before? ________ If yes, what and were you satisfied with the results? ________

____

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 office as soon as possible. I have read and understand the above medical history questionnaire.

Patient Signature ____________________ Date ____________

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