

Medical History

Patient Name: _____

Date: _____

PRECAUTIONS:

- Is there any possibility that you are pregnant? Y N
- Are you breast-feeding? Y N
- Have you recently been treated with any other dermal filler such as Restylane, Juvederm, Sculptra, Radiesse, or Prevelle?

If so, where? _____

Did you experience any hypersensitivity? Please explain _____

- Do you have any permanent implant(s) at the sites to be treated? Y N
- Have you undergone laser skin resurfacing or received a skin peel in the past six weeks? Y N
- Do you suffer from facial herpes simplex or have any active skin conditions, e.g., acne or psoriasis? Y N
- Do you have, or have you ever had, any form of skin cancer? Y N
- What are your expectations of the outcome of the treatment? Y N

CONSIDERATIONS:

- Have you received Accutane treatment in the past 12 months? Y N
- Do you suffer from any known allergies? Y N
- Do you have a history of anaphylactic shock? Y N
- Are you currently taking aspirin, steroids or anticoagulants? Y N
If yes, please specify _____
- Do you suffer from any of the following conditions: angina, epilepsy, diabetes, HIV positive, hepatitis, auto immune disease
- (e.g., rheumatoid arthritis), depression, stress? If yes, please specify _____
- Have you recently undergone any major surgery? Y N
If yes, please specify _____
- Are you currently undergoing dental surgery? Y N
- Do you suffer from fainting or low blood pressure? Y N
- Do you suffer from keloid or hypertrophic scarring? Y N
- Do you have a needle phobia? Y N
- Are you prone to bruising? Y N
- Have you recently been exposed to the sun or sun beds? Y N

IF THE ANSWER TO ANY OF THE ABOVE QUESTIONS IS "YES" YOU MAY DECIDE THAT THE PATIENT IS NOT SUITABLE FOR TREATMENT

