**Patient Information**

**TODAY’S DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Date of Birth Gender: Male Female

Last Name First Name MI Suffix

Street City ST Zip

Home Phone Work Cell

E-Mail Address

Emergency Contact Name Emergency Contact Phone

**Aesthetic History**

*Requested Services (please circle selection):*

**Botox Dysport Perlane Restylane Juvaderm Other**

*Desired Injection Site:* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Have you had Botox/Dysport or other fillers in the last three months? If so, where?*

**General Health History**

*Past Medical Problems:* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Allergies:* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*All Surgeries:* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If you have any of the following conditions, you will be unable to obtain services at this time: ALS (Lou Gehrig), Multiple Sclerosis, Guillian-Barre, Lambert-Eaton, previous plastic surgery to the treatment site, current infection at the treatment site, pregnant and/or nursing, age 65 and above, age 18 and below, known hypersensitivity or allergy to any of the above mentioned products.

\_\_\_\_\_ I certify none of the above apply to me

Please note: It is advised that no aspirin, anti-inflammatory or blood thinners be taken for at least 10 days prior to treatment.

*Patient’s Signature:* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ *Date:* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_