MEDICAL HISTORY

Name ____ Date ______________

Primary Care Provider: ___________________________ Last Visit __________

Medications: Antibiotics Oral Contraceptives Aspirin/Blood Thinners

List other medications: ____

Supplements: ____

Allergies: Latex Lidocaine Aspirin Hydroquinone Hydrocortisone

List other allergies: ____

Do you have any of the following?

Cancer Diabetes Multiple Sclerosis Rheumatoid Arthritis

Seizures Clotting Disorders Oral Herpes

Hepatitis Hypertension Hypoglycemia

Cardiac History Active Infections

List any other chronic medical conditions: ____

Past issues with Toxins Y / N Past Issues with Fillers Y / N

Nursing or Pregnant Y / N Neuromuscular Issues Y / N

Accutane Use within 6 mo Y / N Milk Protein Allergy Y / N

Patient Signature ____ Date ______________

Provider Signature ____ Date ______________