MEDICAL AESTHETIC INTAKE FORM

Name:_____ Phone number:_____
Date of Birth:_____ Email:_____

Please complete the following intake form. Note that all medical information and history discussed is kept private and confidential.

MEDICAL HISTORY	**YES**	**NO**
Are you currently pregnant, breastfeeding, or trying to get pregnant in the next 3 months?		
Do you have any life-threatening allergies (anaphylaxis)?		
Do you have an allergy or sensitivity to: lidocaine, human albumin, lactose monohydrate, cow's milk protein, bee stings, hyaluronidase? (circle)		
Have you had a prior bad reaction to Botox®, Dysport® or dermal fillers?		
Do you have a history of autoimmune disease (Rheumatoid Arthritis, Scleroderma, SLE [Lupus])?		
Do you have any diseases of the nerves or muscles (Lou Gehrig's disease/ALS, Myasthenia Gravis, Multiple Sclerosis, Lambert-Eaton Syndrome, Parkinson's disease)?		
Do you have a history of a bleeding disorder? Do you bruise or bleed easily?		
Are you currently taking, or likely to take in the near future: immunosuppressants, antibiotics, nerve blockers, lincosamides, polymyxins, quinidine, magnesium sulfate?		
Do you take or consume alcohol, Aspirin, Motrin, Aleve, Ibuprofen, Celebrex, Ginkgo Biloba, Vitamin E, St. John's Wort, turmeric, garlic?		
Do you have any active skin infection, inflammation, tumour, or previous surgery in the face or neck?		
Do you have a history of cold sores?		
Do you form thick or raised scars from cuts or burns (keloid scars)?		
After injury, such as cuts or burns, do you experience darkening (hyperpigmentation) or lightening (hypopigmentation) of the skin in that area?		
Do you have a history of cancer, or HIV/AIDS?		
Do you have any other illnesses, health problems, or medical conditions not listed?		

_____

Patient Name (Print) **Signature** **Date**