Hyaluronic Acid/Botox General Client Form

First Name: _____ Last Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Telephone Home: _____ Business: _____ Cell: _____

E-mail: _____ Date of Birth: _____

Family Physician and Address: _____

Do we need to be discreet with messages? __Yes __No May we contact you in emails? __Yes __No

Please answer all of the following questions:

Female patients: Are you or could you be pregnant/nursing? __Yes __No

Do you experience easy bruising or bleeding or excessive bleeding requiring special treatment? __Yes __No

Have you ever had any reaction to any type of anesthetic – dental/surgery? __Yes __No

Do you or any family members suffer from the following neurological disorders:

- Myasthenia Gravis __Yes __No
- Eaton Lambert Syndrome __Yes __No

Do you have Bioaclamide, Dermalive, Dermadeep, Beauticall, Artecoll or Artesense or any semi permanent/ permanent filler in your face? __Yes __No

Please circle if you have or have had any issues with the following:

Eczema Acne Keloid Formation Herpes/Cold Sores Laser Therapy Chemical Peels Dermabrasion

Circle any of the following which you presently have or have had in the past:

- Diabetes
- Cancer
- Heart trouble/angina
- Emphysema
- Tuberculosis
- Asthma
- Thyroid disease
- Migraines/headaches
- Seizures/epilepsy
- Stroke
- Lupus
- High Blood Pressure
- Heart Murmur
- Rheumatic Fever
- Mitral Valve Prolapse
- Congenital Heart Defect
- Cardiac Pacemaker
- Artificial Valve, joint or prosthesis
- Hirsutism (excessive hair growth)
- Anemia
- Sickle Cell Disease
- Blood Transfusions
- Liver disease
- Jaundice
- Stomach Ulcer
- Kidney Disease
- Arthritis
- Sinus Trouble
- Psychiatric Treatment
- Addictions/Alcoholism
- Hepatitis
- Glaucoma
- HIV/AIDS
- Herpes/Cold sores
- Recent dental procedures
- Pace Maker
- Skin conditions
- Skin sensitivities (to sun or other)
- Metal Implants (including IUD)
- Warts
- Blood disorders bleeding/clotting)
- Oral corticosteroids
- Fainting Spells
- Aspirin/ Blood Thinners
- Keloids (excessive scarring)

Have you ever been treated in the past with: Botox __Yes __No

Hyaluronic Acid fillers __Yes __No

If so, have you ever experienced any problems with the procedures? _____

_____

Do you have or have you had any other diseases or medical problems not listed on this form?

_____

List allergies to medications or other substances: _____

Please list medications currently being taken in particular: any non steroidal anti inflammatories (Advil, Motrin, ASA), or Plavix/Coumadin: _____

Please list any non prescription medications/vitamins being taken, in particular Vitamin E, Gingo :

_____

Do you smoke? _____ Amount/wk? _____

Do you drink alcohol?_____Amount/wk? _____Date/type last drink: _____

Who referred you to Inner Glow Spa?_____

If you found through searching/advertising please circle one

Google Search Yahoo Search Google Ad Facebook Ad Twitter Ad Website

I hereby state that the above medical history is, to the best of my knowledge, accurate and complete. If I ever have any change in my health, or my medications change, I will inform the doctor at the next appointment without fail. If deemed advisable, I grant permission for my physician to be contacted for details and advice.

_____ _____

Signature Date