Limited Patient Medical History – Dermal Filler and Neurotoxin Patients

Patient Name: ________________________________ Date of Birth/Age: _________ Date: ________

Please identify any current or past conditions by circling those that apply:

History of adverse reaction to botulinum toxin	History of Anaphylaxis	Multiple Severe Allergies
Facial Acne	Hives	Herpes
Immunosuppressive Therapy	Autoimmune Disease	Facial Rashes
Active Inflammatory process Infection (at proposed injection site)		Myasthenia Gravis
Lambert-Eaton Syndrome		

Have you had prior treatment with: ___ Dermal Fillers (Versa, Juvederm, Restylane)
___ Neurotoxin (Xeomin, Botox, Dysport, Jeuveau)

If so, did you have any adverse reaction? __N __Y

Current Medications (Prescription or frequent Over-the-Counter):

Medication: ________________________________ Dose: ______________ Frequency: _________
Medication: ________________________________ Dose: ______________ Frequency: _________
Medication: ________________________________ Dose: ______________ Frequency: _________
Medication: ________________________________ Dose: ______________ Frequency: _________
Medication: ________________________________ Dose: ______________ Frequency: _________

Current Supplements:
Supplement: ________________________________ Dose: ______________ Frequency: _________
Supplement: ________________________________ Dose: ______________ Frequency: _________
Supplement: ________________________________ Dose: ______________ Frequency: _________

Known Drug Allergies: __ No Known Drug Allergies
Medication: ________________________________ Reaction: ______________ Last Taken: _________
Medication: ________________________________ Reaction: ______________ Last Taken: _________
Medication: ________________________________ Reaction: ______________ Last Taken: _________

Signature of Patient

____ Signature

____________________ Date