Palm Beach
PREVENTIVE MEDICINE

A Balanced Approach to Your Health.

Dermal Fillers Medical History

Today's date: _____

Patient Name: _____ DOB: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Work/Cell: _____ Email: _____

Primary Physician Name: _____ Phone: _____

Age: _____ Ht. _____ Wt. _____ B/P: _____ T: _____ P: _____ R: _____

List all prescription and OTC medications, blood thinners, herbal/natural supplements, or topicals you are currently taking:

_____

List allergies: _____

_____ Are you currently taking Antibiotics? YES | NO

Check any of the following illnesses you have or have ever had in the past:

- ☐ Autoimmune Disease
- ☐ Allergy to Hyaluronic acid/Lidocaine
- ☐ Lupus
- ☐ History of Cold Sores
- ☐ Allergy to Beef /Dairy/Cow's Milk Products
- ☐ Keloid Formation
- ☐ Multiple Severe Allergies/Hypersensitivity to medications

List and Explain Other Medical Conditions not listed above: _____

_____

Previous Hospitalizations/Surgeries: _____

_____

Are you pregnant or lactating (nursing)? [YES] [NO] If yes, you are not a candidate for treatment at this time!

Are you trying to get pregnant? [YES] [NO] If yes, a pregnancy test is needed before treatment (results) _____

Have you had Plastic Surgery or other surgery to your face/neck area? [YES] [NO] If so, when? _____

Have you had any Dermal Filler procedures before? [YES] [NO]

If yes, what filler was used and were you satisfied with the results? _____

_____

I understand the information on this form is essential to determine my medical and cosmetic needs and the provision of treatment. I understand that if any changes occur in my medical history/health I will report it to the office as soon as possible. I have read and understand the above medical history questionnaire. I acknowledge that all answers have been recorded truthfully and will not hold any staff member responsible for any errors or omissions that I have made in the completion of this form.

Patient Signature_____ Date_____