EXCLUSIVE WELLNESS & AESTHETICS MEDICAL HISTORY
Dermal Fillers

Name_____DOB_____Ht_____Wt_____Date_____

Address_____

City_____State_____Zip_____

Phone_____ Email_____

Primary Physician's Name and Number_____
_____

Please list all medications you are currently taking:_____
_____

List Vitamin Supplements you are taking:_____
_____List any Allergies:_____
*Collagen Tested_____Date_____Were there complications?_____

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

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

List any OTHER MEDICAL CONDITIONS not listed above that you currently have or have had in past:_____
_____
Please list any previous hospitalizations/surgeries:_____
_____

WOMEN: Are you Pregnant, Trying to get Pregnant, or Lactating (Nursing)?_____

Have you had Plastic Surgery or other surgery to your face/neck areas & when?_____

_____
Have you had any Dermal Filler procedures before? _____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_____

Practitioner Signature_____Date_____