Health History – Dermal Fillers
West Linn Aesthetic Medicine

Patient Name_____ Date of Birth_____

Address_____

Primary Phone_____ Email_____

Emergency Contact_____ Phone_____

Are you pregnant? Yes or No Trying to get pregnant? Yes or No Breast feeding? Yes or No

Are you prone to Cold Sores on, in, or around your mouth (oral Herpes Simplex)? Yes_____ No_____

Does your skin pigment change easily, dark (hyperpigmentation) or light (hypopigmentation)? Yes or No

Prone to Keloid formation (scar tissue)? Yes_____ No_____

Have you currently had (past 3-4 days) facial treatments (microdermabrasion, facials, laser treatment) exposure to the Sun or artificial UV Light? Yes_____ No_____

Are you allergic to Lidocaine or any topical anesthetic medicine? Yes_____ No_____

Are you, in general, a highly sensitive or allergic type person? Yes_____ No_____

Allergies to anything else, including medications? Please list: _____

_____

Please list ALL current medications, including over-the-counter, vitamins:_____

_____

_____

Are you currently taking/using any of the following…Alcohol, Aspirin, Ibuprofen, Advil, Motrin, St. John's Wort, Vit. E, Vit. A, Retin A, Cod Liver or Fish Oil, Flaxseed Oil, Ginko Biloba, Garlic, Niacin, Warfarin, Coumadin, Heparin, Lovenox, Enoxaprin, Lepirudin, Plavix, Refludan, Ticlopidine, Ticlid, Clopidogrel, Tirofiban, Aggrastat, Eptifibitate, Integrillin? **Circle which ones.** Muscle relaxers? Yes_____ No_____

Please list ALL current and past chronic health conditions: _____

_____

I certify that the above information is true and correct, and that if there are any changes in my health status, medications, and/or allergies that I will notify West Linn Aesthetic Medicine immediately.

Patient Name_____ Patient Signature_____ Date_____

Clinic Use:

Vital Signs: BP_____ HR_____ Temp_____

According to the above stated information,_____, is medically cleared to receive Dermal Filler injections. Addendum? Yes_____ No_____

Physician_____ Physician Signature_____Date_____

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Clinic Use:

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According to the above stated information,_____, is medically cleared to receive Dermal Filler injections. Addendum? Yes_____ No_____

Physician_____ Physician Signature_____Date_____