MARTIN'S Rejuvenation CENTRE

Botox / Fillers Patient Profile

O ☐ S ☐ QB ☐ N ☐

Last Name:_____ First: _____ Initial: _____ Date: _____

Address: _____ City: _____ Postal Code: _____

Telephone: Home ( ) _____ Work ( ) _____

Cellular: ( ) _____ OHIP Number: _____

Date of Birth: Day ____ Month _____ Year _____ Age: ____ Email: _____

Occupation: _____ Are you pregnant, breastfeeding or trying to conceive? _____

Family Physician: _____ City: _____

How may we remind you of your appointment? ☐ Email OR ☐ No Reminder Please

How did you hear about us? MD Referral ☐ Internet ☐ Radio ☐ Facebook ☐ Instagram ☐
Referred by friend ☐ Who? _____ Magazine ☐ Tradeshow ☐

You may not have Neuromodulators or Fillers if you are pregnant, breastfeeding or three months after delivery.

PAST MEDICAL HISTORY

Past Medical History (ie. Cancer, HIV, Hep. C, Diabetes, Surgery etc.) _____

_____

_____

Current Medications including vitamins (dose not required) _____

_____

_____

Are you currently taking immunosuppressant medication? ☐ YES ☐ NO

Allergies (Include meds, type, med treatments and environmental) _____

HAVE YOU EVER HAD ANY OF THE FOLLOWING CONDITIONS: ☐ Cold Sore (Herpes) ☐ Melasma ☐ Rosacea
☐ Acne ☐ Psoriasis ☐ Eczema ☐ Hyper/hypo pigmentation ☐ Keloid (thick) scarring ☐ Warts ☐ Thyroid Imbalance

HAVE YOU PREVIOUSLY HAD?

☐ Botox	☐ Fillers	☐ Facial Laser	☐ Facial Peel	☐ Skin Tightening
☐ Facial Surgery	☐ Facial Trauma	☐ Chronic Headaches	☐ Permanent Fillers/Implants	☐ Tattoo
☐ Hyperhydrosis	☐ Microdermabrasion	☐ Dermabrasion	☐ Laser Hair Removal	☐ Polycystic Ovaries

YOUR CONCERNS:

☐ Face	☐ Lips	☐ Unwanted Hair	☐ Red Spots	☐ Rosacea
☐ Frown Lines	☐ Headaches	☐ Brown Spots	☐ Fat Reduction	☐ Excessive Sweating
☐ Wrinkles	☐ Uneven Skin Surface	☐ Loose Skin	☐ Spider/Varicose Veins	☐ Skin Cancer

Have you ever had a bad reaction to fillers or Botox? ☐ YES ☐ NO

Do you have a history of:

☐ Lupus	☐ Rheumatoid Arthritis	☐ Guillian-Barre Syndrome	☐ Polymyositis	☐ Multiple Sclerosis
☐ Hemophilia	☐ Muscular Dystrophy	☐ ALS	☐ Lambert-Eaton Syndrome	

☐ Other auto-immune or neurological disease _____

In the last 2 weeks have you used: ☐ Blood Thinners ☐ Aspirin ☐ Anti-Inflammatories ☐ Alcohol in past 24 hours
The chance of bruising increases if these substances are used

Do you have an allergy to: ☐ Milk ☐ Eggs ☐ Wasp/Bee

_____	_____	_____
Patient Signature	***Date***	***Physician/Nurse Signature***