



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
 Hyperhidrosis 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