PLATINUM
AESTHETICS MOBILE MEDSPA

CLIENT INFORMATION & MEDICAL HISTORY

In order to provide you with the most appropriate treatment, please complete the following questionnaire.
All information is strictly confidential.

PERSONAL HISTORY

Today's Date_____

First Name_____Middle Initial_____Last Name_____

Date of Birth_____Occupation_____

Home Address_____

City_____State_____ Zip Code_____

Email_____(to notify you of specials & events)

Home Phone (_____) _____ Cell Phone (_____) _____

Employer_____Occupation_____

Employer's Address_____Phone Number_____

Emergency Contact Name and Number_____

How were you referred to us?_____

Treatments of Interest: please check all that apply.

- ○ Botox/Dysport/Xeomin
- ○ Dermal Fillers (Restylane, Juvederm, Perlane, Radiesse, Belotero Balance)

BOTULINUM TOXIN "A" AND/OR DERMAL FILLER MEDICAL HISTORY

Are you currently under the care of a physician? ❑Yes ❑ No

If yes, for what:_____

_____

Primary Physician's Name_____Phone Number_____

DOB_____Age_____Ht_____Wt_____

Please list all the medications you are currently taking (it is required that you list all of them):_____

_____

Are you on any Antibiotics at this time? _____ If yes, which ones? _____

_____

List all Vitamin and Herbal Supplements you are currently taking: _____

_____

Have you ever had an allergic reaction? (List any and all that you have had and describe the reaction you experienced) ❑Food ❑Animal Protein ❑Aspirin ❑Lidocaine qAntibiotics qOthers:_____

_____

Collagen Tested_____Date_____Were there complications? _____

Check any of the following illnesses you have or have had in the past? (Please check all that apply)

❑Myasthenia Gravis ❑Multiple Severe Allergies/Hypersensitivity to medications ❑Hepatitis

❑Neurological Disorders ❑Lambert-Eaton Syndrome ❑Numbness ❑Keloid Formation

❑Autoimmune Disease ❑Vision Problems ❑Allergies to Human Albumin or Bovine (Cow's Milk)

❑Allergies to Beef/Dairy/Cow's Milk Products ❑Muscle Weakness ❑ History of Cold Sores ❑Lupus

❑Parkinson's Disease ❑Multiple Sclerosis ❑Amyotrophic Lateral Sclerosis (ALS) ❑Eye Disease

List and/or Explain Other Medical Conditions not listed above:

Previous Hospitalizations/Operations:

_____

Have you had Plastic Surgery or other surgery to your face/neck areas? If Yes, When? _____

_____

Have you had Botulinum injections and/or Dermal Fillers before? _____

Last Treatment_____ What Area? _____

Were you happy with previous Botulinum and/or Dermal Filler treatments? _____

Please Explain_____

What Dermal Filler was used? _____What Area(s)? _____

Botulinum Toxin "A" questions only:

Have you ever had eyelid/eyebrow droop after Botulinum injections? _____

Do you show a lot of upper eyelid when eyes are open? _____

Do your eyelids feel extra heavy when you don't get enough sleep?_____

Do your eyelids droop without sleep? _____

Areas of special concern to patient? _____

For our female clients only:

Are you pregnant or trying to become pregnant? ❑Yes ❑No Are you Lactating (nursing)? ❑Yes ❑No

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 Platinum Aesthetics Mobile MedSpa as soon as possible. I have read and understand the above medical history questionnaire. I acknowledge that all answers have been recorded truthfully and accurately and will not hold any staff member responsible for any errors or omissions that I have made in the completion of this form.

_____	_____	
Patient Name (please print)	**Patient Signature**	**Date**
_____	_____	
Witness Name (please print)	**Witness Signature**	**Date**

PLATINUM AESTHETICS MOBILE MEDSPA
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