L.I.V. Medical Weight Loss and Aesthetics
8198 Jog Road, Ste. 104
Boynton Beach, FL 33472
Tel: (561)-509-6147
Fax: (561)-509-6013

Dermal Filler Patient History

Name: _____ Date: _____
Address: _____
Telephone: _____ Cell: _____
Date of Birth: _____
Consent signed: Yes No Date: _____
Previous Dermal Filler Yes No Date: _____
Complications: Yes No Date: _____
Type Dermal Fillers: _____
History of Anaphylactic Shock: Yes No Date: _____
History of Allergies: Yes No Date: _____

Medications

Asprin Yes No
Anti-Inflammatories Yes No
Anticoagulants Yes No
Steroids Yes No
Non-Steroidals Yes No
(i.e. Advil, Aleve, Celebrex)

_____
_____
_____
_____

Supplements

Ginko Biloba Yes No
Vitamin A Yes No
Vitamin E Yes No
Garlic Yes No
Flax Oil Yes No

_____
_____
_____
_____

Dermal Filler Patient History (Continued)

Do you have at present, any history of the following medical conditions?

Have you had in the past, any history of the following medical conditions?

1. Multiple Severe Allergies	Yes	No
2. HX of Herpes around the Lips	Yes	No
3. On Immunosuppressive Therapy	Yes	No
4. Autoimmune Disease	Yes	No
5. Medical History	Yes	No

(if answered Yes to any one of the above please explain below)

Comments:

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I have answered the above questions to the best of my knowledge

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_____ _____

Signature Date