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FACIAL ENHANCEMENT HEALTH HISTORY FORM

Date:_____

Name:_____ DOB:_____

Address:_____

City:_____ State:_____ Zip:_____

Home phone:_____ Cell phone:_____ Work Phone:_____

Email:_____ How did you hear about us:_____

Reason for appointment today:_____

Do you have a Brilliant Distinctions account:_____

If not may be create an account for you and help you save money in the future?_____

This information is necessary for your procedure. Please answer yes or no to the following questions:

YES NO

___ ___Are you using any prescribed medications?_____

_____

___ ___Are you using any herbal medications?_____

___ ___Are you taking any anti coagulants, anti inflammatories, Aspirin, Fish Oil,CoQ10 Ginkgo,Vit E?

___ ___Are you pregnant or trying to get pregnant?

___ ___Do you use oral contraceptives or hormones?

___ ___Have you ever had any Facial surgery?_____

___ ___Do you smoke? How much?_____ How long?_____ When did you quit?_____

___ ___Do you spend a lot of time outside or use a tanning bed?

___ ___Do you have any neuromuscular or autoimmune diseases?

___ ___Do you have allergies to latex?

___ ___Do you have a history of Herpes Simplex or Cold Sores?

Which concerns apply to you? Check all that apply:

Uneven skin tone _____ Brown spots (hyperpigmentation) ____ White spots (hypopigmentation)

Hard bumps under the skin ____ Enlarged pores__ Blackheads/whiteheads_____

Acne_____ Excessive Oiliness____ Skin Laxity_____ Upper lip lines_____ Wrinkles _____

Scarring_____ Dry patches_____

What is your skin type: __ Dry ____ Combination ____ Oily ____ Normal

Please check the products you are currently using and list the BRAND NAMES of Cosmetic Products:

__ Cleanser _____ ____ Soap _____ ____ Toner_____

__ Moisturizer_____ ____ Night Cream _____ ____ Masks _____

__ Eye Cream_____ ____ Astringent_____ ____ Glycolic Cleanser_____

__ Scrub _____ ____ Sunscreen _____ ____ Salicyclic Cleanser_____

__ Vitamin A Cream(Retin A)_____ ____ Vitamin C Cream _____ ____ Alpha Hydroxy Cream_____

Have you ever had the following injectables or implants:

__ Botox, Dypsort or Xeomin ____Juvederm, Vollure, Vollbella, Voluma ____Restylane Products

__Collagen If so when was your last injection?_____ What area:_____

Have you ever had cosmetic surgery/procedures?_____

Were you pleased with the results?_____

Please check any health problems, past or present:

__ Seizures ____ Liver Disease ____ Skin Cancer____ Hepatitis_____ Asthma____ Hormonal Problems

__ Diabetes __ Cystic Acne __ Thyroid ____ Cancer ____High Blood Pressure __ Heart Problems

__ Lupus __ Vasovagal Syncope/Fainting ____ Other:_____

Do you have the following chronic skin disorders:

__ Psoriasis ____ Dermatitis ____Eczema __ Keloid Scarring __ Fever Blisters __ Cold Sores

__ Sun Blisters ____ Herpes Simplex/Blisters

_____ _____

Patient Signature Date

Provider Signature

Date