Kiss Me
cosmetic injectables

Medical/Health History

Name_____**DOB**_____

Please list all medications you are currently taking:

Allergies or allergic reactions (including latex):

Are you on any antibiotics at this time? **yes no**

Face

Pain: **yes no**
Paralysis/weakness: **yes no**
Trauma/injury to area: **yes no**
Surgeries: **yes no**
(if yes, list dates)_____

Dental

Tooth pain: **yes no**
Missing teeth: **yes no**
Infections: **yes no**
Dental implants: **yes no**
Problem with dental Anesthesia? **yes no**
TMJ (teeth clenching): **yes no**

Skin

Cold sores: **yes no**
Shingles: **yes no**
Melasma: **yes no**
Hypertrophic/keloid scarring: **yes no**
Acne: **yes no**
Rosacea: **yes no**
Scars: **yes no**
(If yes, location?)_____
Cellulite: **yes no**
MRSA (resistant staph infection): **yes no**
Permanent makeup/tattoos: **yes no**
Lesions: **yes no**
(if yes, have you been seen by a dermatologist?)_____

Hair

brittle: **yes no**
thinning: **yes no**

Eyes

Blurred vision: **yes no**
Double vision: **yes no**
Vision loss: **yes no**
Eyelid surgery: **yes no**

Neuromuscular

Multiple Sclerosis: **yes no**
Bell's Palsy: **yes no**
Seizure Disorder: **yes no**

Endocrine

Thyroid Disorder: **yes no**
Polycystic Ovaries: **yes no**

Reproductive

Pregnant (or considering becoming pregnant): **yes no**
Nursing: **yes no**
Menopause (natural/surgical): **yes no**

Mental Health

Depression: **current or resolved**
Anxiety: **current or resolved**
Eating Disorder: **yes no**
Substance Abuse: **yes no**

Autoimmune

fibromyalgia: **yes no**
chronic fatigue: **yes no**
(if yes, how many flares a year)_____
Asthma: **yes no**
Anaphylaxis: **yes no**
Metal Implants: **yes no**
(if yes, location)_____
Defibrillator: **yes no**
Pacemaker: **yes no**

Lifestyle

Sun exposure:
do you work outdoors? **yes no**
Sleep:
8 hours? **yes no**
Difficulty falling asleep: **yes no**
Well rested upon waking: **yes no**

Nutrition

Do you eat more than you intend: **yes no**
Do you skip meals: **yes no**
Water intake: **how many cups/day**_____
Smoker: **past current**
Exercise: **Type**_____**How often**_____

Recent life stressors

Job loss	**yes**	**no**
Death in family	**yes**	**no**
Divorce	**yes**	**no**
Move	**yes**	**no**

Have you had any cosmetic injections before? **yes no**
If yes, what type, and location_____

If yes, were you happy with previous treatment(s)? **yes no**
If no, please explain_____
Have you ever had eyelid/eyebrow droop after Botox? **yes no**

Areas of special concern regarding prior treatments:
_____
_____

Other health/lifestyle concerns or conditions not listed in the categories above:
_____
_____

Please initial:

____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/health, I will report it to the office as soon as possible.

____I have read and understand the above medical health questionnaire.

____I acknowledge that all answers have been recorded truthfully and will not hold any staff member responsible for any errors or omissions that I have made in the completion of this form.

Patient signature_____Date_____

~~For Practitioner Use~~

I have read the patient history and have determined that patient is cleared for treatment.

NP/DO signature_____Date_____
_____

Practitioner Notes:
_____
_____
_____
_____