BELLA DERMA MEDICAL SPA, LLC
BOTOX & DERMAL FILLERS NEW CLIENT HISTORY

First Name: _____ Last Name: _____ DOB: _____

Address: _____ City: _____ State: _____ Zip: _____

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

Email Address: _____

How did you hear about us? _____ Ethnic Background: _____

List of medications and/or vitamins that you are taking: _____

_____

Allergies: _____ Are you taking antibiotics at this time? _____

Collagen Tested: _____ Date: _____ Were there complications? _____

Primary Physician's Name & Number: _____

MEDICAL HISTORY

Yes	No	Myasthenia Gravis
Yes	No	Hepatitis
Yes	No	Eye Disease
Yes	No	Autoimmune Disease
Yes	No	Vision Problems
Yes	No	Numbness

Yes	No	Muscle Weakness
Yes	No	Multiple Sclerosis
Yes	No	Lupus
Yes	No	Parkinson's Disease
Yes	No	Neurological Disorders
Yes	No	Lambert-Eaton Syndrome

Yes	No	History of Cold Sores
Yes	No	Sensitivity/Allergy to Lidocaine
Yes	No	Keloid Formation
Yes	No	Amyotrophic Lateral Sclerosis
Yes	No	Allergy to beef or dairy products
Yes	No	Hypersensitivity to medications

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 area and when: _____

_____

WOMEN: Are you pregnant, trying to get pregnant or lactating? _____

BOTOX

Have you had Botox injections before? _____ Last treatment: _____

What areas? _____ Were you happy?_____

If not, please explain: _____

Have you ever had eyelid/eyebrow droop after Botox? _____

Do your eyelids droop without sleep? _____

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

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

_____ _____

Patient Signature Date