CLIENT QUESTIONNAIRE

Name: ____ **Date:** ________________

Date of Birth: ___________________

MEDICAL INFORMATION:

NO	YES	
____	____	Allergies – history of severe allergy or anaphylaxis
____	____	Aspirin, Ibuprofen: If yes, when? ______________________________
____	____	Autoimmune disease, HIV, Lupus, Hepatitis
____	____	Bruise easily, Cuts
____	____	Currently Pregnant or Breast Feeding?
____	____	History of Keloids scarring
____	____	Currently on immunosuppressive therapy
____	____	Currently tanning or tanning booth
____	____	History of oral herpes (fever blisters)
____	____	Any condition not listed: _____________________________________
____	____	Currently under the care of a physician?
____	____	Currently taking any medication (including OTC & Herbal supplements taken regularly)? Please List: __________________________________

____

I am interested in the following services:

Radiesse ______ Juvederm ______ Botox ______

Reviewed by: ________________________________ Date: _______________

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