LL Aesthetics, LLC

MEDICAL HISTORY FORM

Name:_____

City/State: _____ Zip: _____

Phone: _____ DOB: _____ Female:_____ Male:__

Email: _____

Medical History and Previous Operations: _____

_____

Medications/ Supplements: _____

ALLERGIES: _____

Any allergies to LATEX, Albumin, Gram positive Bacterial or strep protein (filler),

Or Cow's milk protein? _____Y:_____ N:_____

Pregnant or lactating? Y: _____ N: _____

Do you have or history of Herpes I or II infection? Y: _____ N: _____

Have you taken any ASPIRIN or ASPIRIN products recently? (ASPIRIN, WARFARIN, COUMADIN, ADVIL,MOTRIN,ALEVE, IBUPROFEN) Y:_____ N: _____

Any recent use of Vitamin E, Garlic tablets, Ginkgo Biloba, St. John's Wort, Fish Oil, dipyridamole (Persantine), clopidogrel (Plavix) ? Y:_____ N: _____

Circle any of the following illnesses you have or have ever had in the past (or family history of) :

Myasthenia Gravis Hepatitis Eye Disease Autoimmune Disease

Numbness Vision Problems Amyotrophic Lateral Sclerosis (ALS)

Eaton Lambert Disorder Muscle Weakness

I understand this information is essential to determine my medical and cosmetic needs and the provision of treatment. I understand if any changes occur in my medical history/health I will report it to the office as soon as possible. I have read and understand the above questionnaire and have answered truthfully without omissions.

CLIENT SIGNATURE:_____