STEPHENS CITY
convenience clinic
AESTHETICS

160 Warrior Drive, Stephens City, VA 22655
Phone: 540-508-4539 | Fax: 540-508-4441
www.scfmcc.com

Botox & Dermal Fillers Client History

First Name: _____ Last Name: _____ DOB: _____

Address: _____

City: _____State: _____ Zip: _____

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

Email Address: _____

Emergency Contact: _____ Emergency Contact phone number: _____

How did you hear about us? _____

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

_____

_____

_____

_____

_____

_____

Allergies: _____

Do you have any history of allergy to eggs or egg products? _____

Are you taking antibiotics at this time? _____

Do you smoke? _____

Primary Physician's Name & Number: _____

MEDICAL HISTORY

Myasthenia Gravis	☐ Yes ☐ No	Sensitivity/Allergy to Lidocaine	☐ Yes ☐ No
Parkinson's Disease	☐ Yes ☐ No	Eye Disease	☐ Yes ☐ No
Amyotrophic Lateral Sclerosis	☐ Yes ☐ No	Lupus	☐ Yes ☐ No
Neurological Disorders	☐ Yes ☐ No	Autoimmune Disease	☐ Yes ☐ No
Numbness	☐ Yes ☐ No	Keloid Formation	☐ Yes ☐ No
Muscle Weakness	☐ Yes ☐ No	Vision Problems	☐ Yes ☐ No
History of Cold Sores	☐ Yes ☐ No	Allergy to beef or dairy products	☐ Yes ☐ No
Hepatitis	☐ Yes ☐ No	Lambert-Eaton Syndrome	☐ Yes ☐ No
Multiple Sclerosis	☐ Yes ☐ No		

List and/or explain other medical conditions not listed above: _____

_____

Continued>

Previous Hospitalizations/Operations:

_____

_____

Have you had plastic surgery or other surgery to your face/neck area ☐ Yes ☐ No
If Yes, what procedure was done and when? _____

For our female clients:

Are you pregnant or trying to become pregnant? ☐ Yes ☐ No
Are you breastfeeding? ☐ Yes ☐ No
Are you using contraception? ☐ Yes ☐ No

What services are you interested in today?_____

BOTOX

Have you had Botox injections before? ☐ Yes ☐ No
Last treatment: _____
What area(s)? _____
Were you happy? ☐ Yes ☐ No
If not, please explain:

_____

_____

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

FILLERS

Have you had filler injections before? ☐ Yes ☐ No
Last treatment: _____
What area(s)? _____
Were you happy? ☐ Yes ☐ No
If not, please explain:

_____

_____

Have you ever had an adverse reaction after receiving a dermal filler in the past? ☐ Yes ☐ No
If Yes, Please explain:

_____

_____

I certify that the preceding medical, medication and personal history statements are true and correct. I am aware that it is my responsibility to inform the doctor or other health professional of my current medical or health conditions and to update this history. A current medical history is essential for the caregiver to execute appropriate treatment procedures.

Patient Signature _____ Date: _____