Cosmetic Injection Assessment

Date ______________

First Name ______________________ Last Name ______________________

Street Address: ______________________________________ Apt# ______

City ______________________ State ________ Zip Code ________

Home ( ) ______________________ Work ( ) ______________________

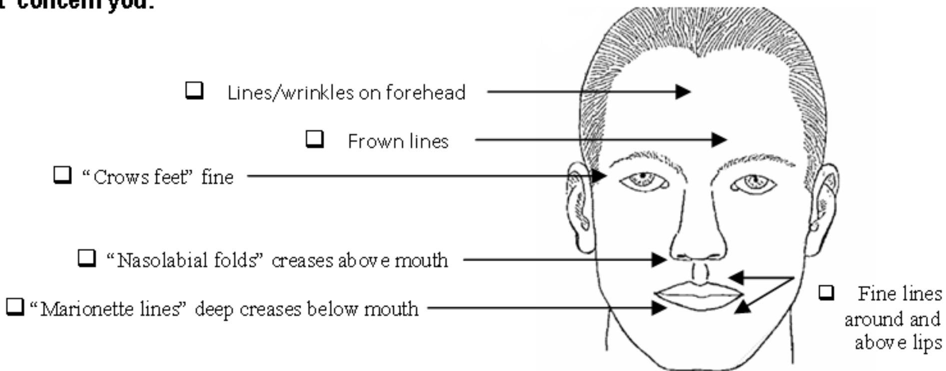
Cell ( ) ______________________ FAX ( ) ______________________

E-Mail ______________________ Date of Birth ______________________

How did you hear about us? ______________________________________

1) Please check the areas that concern you:

- ❑ Lines/wrinkles on forehead
- ❑ Frown lines
- ❑ "Crows feet" fine
- ❑ "Nasolabial folds" creases above mouth
- ❑ "Marionette lines" deep creases below mouth
- ❑ Fine lines around and above lips



2) Have you ever had Botox? Yes No **Date of last injection** ______________

3) Have you ever had a dermal filler such as Restylane, Perlane, Juvederm or other? Yes No
Date of last injection ______________

4) Have you ever had facial laser resurfacing, facial peels or IPL? Yes No
Has it been more than a month since your last procedure? Yes No

5) Have you had reconstructive or facial plastic surgery? Yes No **Date of last procedure** ______________

6) Have you ever had: Fever Blister Cold sore Canker sores Oral herpes

7) Have you ever been diagnosed with any of the following conditions?
- A neuromuscular condition such as Myasthenia Gravis or ALS? Yes No
- Bell's Palsy? Yes No
- A heart condition such as heart arrhythmia or heart attack? Yes No

8) Are you allergic to eggs or tetanus? Yes No

9) Are you: Currently taking any aminoglycoside antibiotics? Yes No
Currently taking any form of chemotherapy or IV infusion for a chronic medical condition? Yes No

10) Do you have any food allergies? If yes, please list: ______________________________________

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GREENVILLE HEALTH SYSTEM
Carolina Aesthetics