Aesthetics Form for

VALLEY MEDICAL WEIGHT LOSS

First Name_____ Last Name_____
Address _____City_____State_____ Zip _____
Date of Birth _____ Age _____ Sex M / F
Phone _( )_____
Emergency Contact _____ Phone _( )_____
Primary Care Physician _____
Email : _____@_____

□ *Check if you do not wish to be contacted via phone or email*

Have you ever had or currently have any of the following

	Yes	No	Not Sure		Yes	No	Not Sure
Myesthenia Gravis	☐	☐	☐	Allergies	☐	☐	☐
Eye Disease	☐	☐	☐	Allergies to Cows Milk (Bovine)	☐	☐	☐
Hepatitis	☐	☐	☐	Neurological Disorders	☐	☐	☐
Autoimune Disease	☐	☐	☐	Lambert Eaton Syndrome	☐	☐	☐
Vision Problems	☐	☐	☐	Latex Allergies	☐	☐	☐
Numbness	☐	☐	☐	Lidocaine Sensitivity	☐	☐	☐
Muscle Weakness	☐	☐	☐	Novacaine Sensitivity	☐	☐	☐
Parkinson's Disease	☐	☐	☐	Keloid Scarring	☐	☐	☐
Multiple Sclerosis	☐	☐	☐	Are you Pregnant or Nursing	☐	☐	☐
Amyotrphopic Lateral Sclerosis (ALS)	☐	☐	☐	Currently on Antibotics	☐	☐	☐
History of Cold Sores/Herpes	☐	☐	☐	Currently on Retin-A or Accutane	☐	☐	☐
Anaphylaxis	☐	☐	☐	Multiple Severe Allergies	☐	☐	☐
Immunosuppressive Therapy	☐	☐	☐	Facial Rashes	☐	☐	☐
Hives	☐	☐	☐	Facial Acne	☐	☐	☐
Active Infammatory Process Infection	☐	☐	☐	Allergery to Lidocaine	☐	☐	☐

(at proposed injection site)

If yes, please explain: _____

_____

List or Explain any Medical Conditions: _____

_____

Do you take any medications? ☐ ☐

List all your medications _____

Aspirin Y/N Anti-Inflammatories Y/N Anticoagulants Y/N Steroids Y/N Non-Sterodials Y/N

(i.e. Advil, Aleve, Celebrex,etc)

Do you take the following supplements?

Ginko Biloba Y/N Vitamin A Y/N Vitamin E Y/N Garlic Y/N Flax Oil Y/N

Have you had Plastic Surgery or othe surgery to your face/neck areas? Y/ N

If so, when? _____

Have you had Dysport/Botox/Xeomin injections before? Y/N

If so, when: _____

What areas were treated? _____

Have you ever had eyelid/eyebrow droop after Botox/Dysport/Xeomin? Y/N

Do your eyelids droop without sleep? Y/N

Have you had Dermal Fillers before? Y/N

If so, when: _____

What areas were treated? _____

Did you have any adverse effects? Y/N

If yes, explain: _____

How did you hear about us? ☐ In-House Advertising ☐ TV ☐ Radio ☐ Referral

☐ Internet ☐ Friend/Family* _____

PATIENT CONSENT

The above information is a true representation of my current health status. I also understand this if any changes occur in my medical history/health I will report it to the office. I have read and understand the above and hereby agree to treatment administered to me, including the use of Aesthetics. I, the undersigned, having been informed by Valley Medical Weight Loss of the hazards and possible consequences involved in treatment by medications, supplements, injections, and nevertheless consent to such treatment and agree to hold Valley Medical Weight Loss free and harmless of any claims, demands, or suits for damage from any injury or complications whatsoever, save negligence, that may result in such treatment.

VALLEY MEDICAL WEIGHT LOSS does not give refunds on any products or services rendered.

IF YOU SUSPECT YOU ARE PREGNANT YOU MUST INFORM THE PHYSICIAN OR A MEMBER OF OUR STAFF

NURSING MOTHERS or PREGNANTS SHOULD NOT BE ADMINISTERED BOTULINUM TOXIN "A" or DERMAL FILLERS, or KYBELLA.

Signed: _____ Date: _____

If patient is under the age of 18, a parent or guardian must sign above.