TrüYou

Plastic and Reconstructive Surgery

MEDICAL HISTORY FOR INJECTABLES

Name: ______________________________ Sex: M F Today's Date: ______________

Age: ________ DOB: ______________

Latex Allergy: Yes No **Tape Allergy**: Yes No Specify kind ______________________

ALLERGIES to FOOD/DRUG: Yes No Please list below, indicating reaction

______________ ______________ ______________ ______________

MEDICATIONS: List dosage or number of pills per day (use an additional sheet, if necessary)

Prescription Drugs | Non-Prescription (Vitamins; Herbs)

______________ ______________ ______________
______________ ______________ ______________
______________ ______________ ______________

Regular Aspirin Use: Yes No Dosage Frequency: ______________
NSAID (Advil, Motrin, and Ibuprofen): Yes No Dosage / Frequency: ______________
Cortisone/Steroid Injections in the Past Year: Yes No Date(s) and injection location: ______________

Smoke: Yes No Amount: ________ Coffee/Tea/Cola: Yes No Amount: ______________
Alcohol: Yes No Amount: ________ Daily Exercise: Yes No Amount: ______________

PERSONAL HISTORY: Please list any medical conditions you are currently being treated by a physician for:

date treatment began | physician treating | briefly describe the condition

____
____

I certify that the above information is correct and complete to the best of my knowledge. I will not hold my physician or his/her staff responsible for any errors or omissions that I may have made in the completion of this form. This will serve as authorization and consent for medical use of injectable products for fine lines and wrinkles.

Patient Signature: ______________________________ Date: ____________

For Office Use Only
Reviewed by: Date:

10/05/2009