**Medical History form for Dermal Fillers**

**First Name Last Name Date of Birth (DD/MMM/YYYY)**

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**BC Care Card Phone Email**

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**Address Family Doctor**

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**Significant Medical/Surgical History**

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**Current Medications** (Please include over-the-counter medicines and herbal or dietary supplements taken regularly.)

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**Allergies**

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**Smoker** 🞎Yes 🞎No

**History of Cold Sores (Herpes)** 🞎Yes 🞎No

**Currently breastfeeding or pregnant** 🞎Yes 🞎No

**History of keloid scarring** 🞎Yes 🞎No

**Recent intake of Aspirin, Advil, anti-inflammatoris, blood thinners, Vit E, omega 3 supplements** 🞎Yes 🞎No

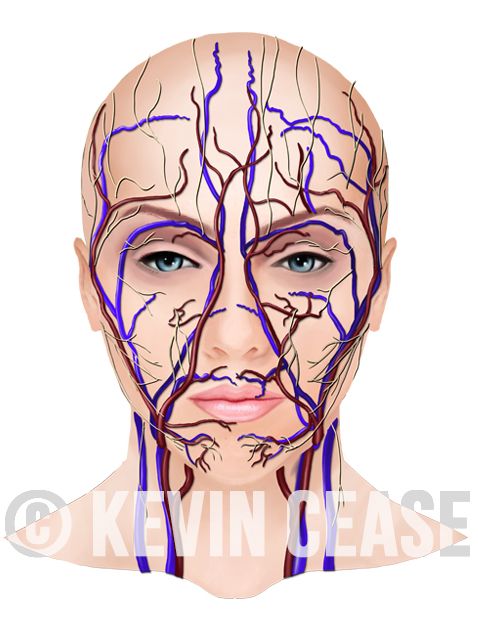
**Permanent fillers like silicone or Artefill or Belafill** 🞎Yes 🞎No

**Plastic surgery to face** 🞎Yes 🞎No if yes what kind and when?

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**Autoimmune disease** 🞎Yes 🞎No If yes what?

**Dermal Filler Lot Number and Expiration**

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