

Your Name: _____ Date of Birth: _____

Address: _____

Phone: _____ Email: _____

Primary Physician: _____ Phone: _____

Current Medications: _____

List Known Allergies: _____

Currently Taking Antibiotics?: Yes No

Please check any of the following medications if you are taking them:

Aspirin Advil Blood Thinners Vitamin E

Please check any of the following illnesses you currently have or have experienced in the past:

Myesthenia Gravis Hepatitis Eye Disease Autoimmune Disease

Vision Problems Muscle Weakness Multiple Sclerosis Neurological Disorders

Parkinsons (ALS) Amyotrophic Lateral Sclerosis Lambert-Eaton Syndrome

Women - are you pregnant, trying to get pregnant, lactating (nursing)? Yes No

Have you had plastic surgery or other surgery to your face/neck areas? Yes No

Have you had Fillers before? Yes No If yes, date of last treatment: _____

Happy with prior Filler results? Yes No If no, please explain: _____

Areas of special concern? : _____

List any other medical conditions or hospitalizations/operations: _____

How did you find Revive? : _____

By completing and signing this form, I understand the questions asked of me and the information I have provided to be true, current and accurate. Should my medical health change, I will notify the office immediately. I do not hold any staff member responsible or liable for any errors resulting from omission in this form. I understand the information obtained is essential to determine my medical and cosmetic needs and provisions of treatment. Furthermore, by signing this form I give my consent for photographs to be taken to accurately document my treatment. I give my permission for my photos to be used for advertising as needed by Revive Medial Aesthetics.

Patient Signature

Date Signed