Aislinn Medical Spa

Dermal Filler Consultation

Patient Name: _____ DOB: _____ Date: _____

Patient Concerns: _____

_____

Patient History:

Do you have a history of cold sores?	Y	N	
Do you have a history of keloids (scaring)?	Y	N	
Do you have acne?	Y	N	
Do you have sensitive skin in which you break out in hives or a rash?	Y	N	
Have you ever had eyelid or facial surgery?	Y	N	When? _____
Are you or could you be pregnant?	Y	N	
Are you currently under a specialist doctor care?	Y	N	Where? _____
Have you had dermal fillers in the past?	Y	N	

When: _____ Where: _____

Are you currently taking anything that can thin your blood?

☐	NSAIDS	☐	Vitamin E
☐	Asprin	☐	Ginko Biloba
☐	Anticoagulant	☐	Omega 3 Fatty Acid
☐	Fish Oil	☐	Prenatal Vitamin

Do you have any other Diseases/Disorders: _____

Allergies _____

Medications: _____

Physical Exam: _____

_____

_____

Plan: _____

_____

Education Given:

- □ Mechanism of Action of Dermal Fillers
- □ Side Effects of Dermal Fillers
  (Erythema, Swelling, Bruising, Pain, Tenderness, Lumps/Bumps, Infection, Blindness, Stroke, Tissue Necrosis, Scarring)
- □ Post Treatment Care including *For the next 24 hours avoid
  (Strenuous activity, Excessive sun/heat exposure, ASA, NSAID's, Alcohol, Being face down)

Provider Signature: _____ Date: _____