# Saving Face, LLC

1011 N. Lindsay St., Suite 201, High Point, NC 27262 • (336) 886-4114 • Fax: (336) 886-5536

**HISTORY FORM**

Date:_____ Name: _____

Date of Birth: _____ Primary Care and/or Medical Doctor: _____

Current Medications (including vitamins and herbs): _____

_____

Drug Allergies: _____ Circle Reaction: rash, nausea, itching, other _____

_____ _____

List Previous Surgeries and Dates: _____

_____

_____

Previous Botox and/or fillers: ☐ YES ☐ NO Date:_____ Where?_____

Do you have a history of :

| | | | |
|---|---|---|---|
| Heart Disease | ☐ YES ☐ NO | Liver Disease | ☐ YES ☐ NO |
| High Blood Pressure | ☐ YES ☐ NO | Auto-Immune Disorders | ☐ YES ☐ NO |
| Mental Disease | ☐ YES ☐ NO | Neuro-muscular Disease | ☐ YES ☐ NO |
| Bleed or Bruise Easily | ☐ YES ☐ NO | Cancer | ☐ YES ☐ NO |
| Diabetes | ☐ YES ☐ NO | Cold Sores/Fever Blisters | ☐ YES ☐ NO |

Other: _____

If you answered "YES" to any of the above questions, please provide details:

_____

_____

_____

_____

Are you Pregnant? ☐ YES ☐ NO Nursing? ☐ YES ☐ NO

Do you smoke? ☐ YES ☐ NO packs/day _____

Do you drink alcohol? ☐ YES ☐ NO Alcohol per week: _____