sarah ELLIS

SARAH SCHMIDT ELLIS, DMD

General and Cosmetic Dentistry

Dermal Filler Medical History:

Name: _____ Date: _____
DOB: _____
Address:_____
City: _____ State:_____ Zip:_____
Telephone #: (Home/Cell)_____

Primary Physician Name/Number: _____
Please List all medications you are currently taking:_____
_____
Please List all vitamin supplements you are taking: _____
_____
Allergies: _____
Are you pregnant, trying to get pregnant, or lactating (nursing)?_____

Have you been Collagen Tested: Y N NA Date:_____
Were there complications?: _____

Please circle any of the following illnesses you have or have had in the past:

Multiple severe allergies	Hypersensitivity to medications.	Allergy to Lidocaine
Autoimmune Disease	History of cold sores	Allergy to beef (collagen)
	Lupus	

Have you had plastic surgery or other surgery to face/neck area? Y N
If so when/what? _____
Have you had any dermal filler procedures before? Y N
If yes, What? _____
Were you satisfied with the results? _____

I understand the information on this form is essential to determine my medical and cosmetic needs and provision of treatment. I understand that if any changes occur in my medical history I will report it as soon as possible.
I have read and understand the medical history questionnaire.
I acknowledge that all answers have been recorded truthfully and will not hold any person responsible for errors or omissions that I have made in the completion of this form.

Patient Signature: _____
Date: _____