FrankenMuth Medical Associates
www.frankenmuthmedical.com
989-502-1122

Cosmetic Injection Intake Form

Name: _____ Date of Birth: _____

Address: _____

Phone: _____ Email: _____

Emergency Contact Information:

Name: _____ Relationship: _____

Phone: _____

What areas would you like to get treated and why?

_____

_____

_____

_____

Past Cosmetic Treatment History: Have you had any cosmetic treatments in the past such as plastic surgery, Botox, Dysport, Restylane or Juvederm fillers or permanent fillers? **YES** **NO**

If you answered yes, please give approximate date and description: _____

_____

_____

Past Medical History: Please list all of your current medical conditions.

_____

_____

_____

Medications: Please list all of your current prescription, OTC and herbal products that you are taking.

_____

_____

_____

Allergies: Please list any allergies.

_____

Are you pregnant or nursing? **YES** **NO**