

Dermal Filler/Sculptra Patient Questionnaire	
Name:	Date:
Medical History	
Do you get cold sores?	☐ Yes ☐ No
Medications	
Have you taken any blood-thinning medications such as aspirin, ibuprofen or fish oil in the past week?	☐ Yes ☐ No
Dental Work	
Have you had any dental work, including cleanings, in the last 4 weeks?	☐ Yes ☐ No
Do you have any dental treatments scheduled in the next 4 weeks?	☐ Yes ☐ No
Vaccinations	
Have you had any vaccinations in the last 4 weeks?	☐ Yes ☐ No
Illness and Infection	
Have you been ill or treated for an infection in the past 3 weeks?	☐ Yes ☐ No
Travel	
Are you traveling out of state in the next 72 hours?	☐ Yes ☐ No
Reviewed By:	

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MEDICAL AESTHETICS & WELLNESS