Gregory Azia M.D., P.C.
Kristin Kenny, RN
399 Ocean Avenue
New London, CT, 06320

Injectable/Dermal Filler Patient History

PATIENT INFORMATION

Name (Last, first, middle initial) ______________________ Date ______________________

Date of Birth ______________________

Phone Number & Email Address ______________________

Street address, City, ST, ZIP Code ______________________

Primary Care Physician ______________________ City/State ______________________

Pharmacy ______________________ City/State ______________________

How did you hear about Defy Nature?

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Previous Facial Filler Injections: **YES / NO**

If answered YES: Type of injection & date of service

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If answered YES: Were there complications? **YES / NO**

If answered YES: Please explain:

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List of current medications:

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Medications		
Aspirin	Yes	No
Anti-Inflammatories	Yes	No
Anticoagulants	Yes	No
Steroids	Yes	No
Non-Steroidal (i.e. Advil, Aleve)	Yes	No
Supplements		
Ginko Biloba	Yes	No
Vitamin A	Yes	No
Vitamin E	Yes	No
Garlic	Yes	No
Flax Oil	Yes	No

Medical Conditions		
Multiple Severe Allergies	Yes	No
Herpes/Cold Sores on Lips	Yes	No
On Immunosuppressive Therapy	Yes	No
Autoimmune Disease	Yes	No
Sensitivity to Lidocaine	Yes	No
Do you have any concern with redness?	Yes	No
Allergies to Beef or Chicken	Yes	No
Lupus	Yes	No
Pregnant or Breastfeeding	Yes	No
History of hypertrophic scarring or keloid formation	Yes	No
Acne, rosacea, seborrheic, dermatitis psoriasis	Yes	No
Allergic history including severe allergic reactions (anaphylaxis)	Yes	No
Immune responses to common allergens	Yes	No
Allergy to natural rubber latex	Yes	No
Allergy to hyaluronic acid products	Yes	No
Any other known issues during previous dermal filler treatments	Yes	No
Under concomitant anticoagulant therapy, antiplatelet therapy or have a history of bleeding disorders, clotting disorders such as hemophilia or connective tissue disorders such as systemic lupus erythematosus	Yes	No

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If you have answer YES to any of the above, please explain below:

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*Please note our office policy:

If you are unable to make your scheduled appointment and you do not notify us 24 hours prior to the appointment, a $25.00 fee will be included in your next procedure.

I have answered and acknowledge the above questions and statements to the best of my knowledge.

____ ______________________

Signature Date

DEFY NATURE
Innovative Skincare

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Fitzpatrick Skin Type Worksheet

Name: **Date:**

Score		0	1	2	3	4
	What is the color of your eyes?	Light Blue, Gray or Green	Blue, Gray, or Green	Blue	Dark Brown	Brownish Black
	What is your natural hair color?	Sandy Red	Blond	Chestnut, Dark Blond	Dark Brown	Black
	What is the color of your unexposed skin?	Reddish	Very Pale	Pale with Beige Tint	Light Brown	Dark Brown
	Do you have Freckles on Sun exposed areas?	Many	Several	Few	Incidental	None
	What happens when you stay in the sun to long?	Painful Redness, Blistering, Peeling	Blistering Followed	Burns sometimes followed by Peeling	Rare Burns	Never had Burns
	To what degree do you turn Brown?	Hardly or Not at all	Light color Tan	Reasonable Tan	Tan Very Easily	Turn Dark Brown Quickly
	Do you turn brown several hours after sun exposure?	Never	Seldom	Sometimes	Often	Always
	How does your face respond to the Sun?	Very Sensitive	Sensitive	Normal	Very Resistant	Never a Problem
	When did you last expose yourself to the sun tanning bed or self-tanning creams?	More than 3 Months ago	2-3 Months ago	1-2 Months ago	Less Than 1 Month ago	Less than 2 Weeks ago
	Do you expose the area to be treated to the sun?	Never	Hardly Ever	Sometimes	Often	Always

Total Score: Skin Type:	**Score**	**Fitzpatrick Skin Type:**
	0-7	I
	8-16	II
	17-25	III
	26-30	IV
	Over 30	V-VI

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Skin Concerns		
Do you have any concerns with the appearance of your skin?	Yes	No
Do you want to learn more about at home skin care?	Yes	No
Do you have any issues with wrinkles or fine lines?	Yes	No
Do you have any issues with sun damage or age spots?	Yes	No
Do you have any issues with large pores or skin texture?	Yes	No
Do you have any concern with redness?	Yes	No