KISS AESTHETICS
BY KIM BURKE

Client history form

Name: _____ **Date:** _____

Date of Birth: _____ **Age:** _____

Phone:_____

Address: _____**City:** _____ **State:** _____ **ZIP:** _____

How did you hear about us? _____

How to confirm appointment: TEXT CALL Ok to leave message: YES NO

email: _____ **Current medications/dose:** _____

Instagram @ _____

Allergies: (foods/medications): _____

Have you had any of the following:

Plastic surgery to face/procedures to face?	Y N
Botox, Dysport, Xeomin or dermal fillers in the past 3 months?	Y N
Date of last treatment/number of units: _____	
Do you get cold sores, fever blisters, or herpes breakouts to face/lips?	Y N
Are you currently pregnant/breastfeeding?	Y N
Uncontrolled diabetes, cardiac disease, autoimmune disorders?	Y N
Have you ever had a reaction to milk, sucrose, lactose, albumin, eggs, or botulinum toxin type A?	Y N
History of facial asymmetry, ptosis, anatomic defects?	Y N
History of Bell's palsy/facial nerve palsy?	Y N
Taking blood thinners (anticoagulants, anti-platelets, etc) of any kind?	Y N
Currently taking any antibiotics not limited to aminoglycoside antibiotics (gentamicin, polymicin)?	Y N