

New England Dermatology & Laser Center
3455 Main Street, Ste. 5
Springfield, MA 01107
(413) 733-9600
www.nedlc.com

KYBELLA CONSULTATION

Name: _____ Chart # _____ Date: _____

Chief Complaint:

Please answer the following questions. Please check yes or no. If yes please describe.

- Have you had any medical, laser, surgical, plastic surgery, radiation, or any other relevant medical treatment in or near the neck area? Y ____ N ____

- Have you had or plan to have any medical, laser, surgical, plastic surgical, radiation, or any other relevant treatment to the face, chin, or neck? Y ____ N ____

- Have you had any numbness of your face or neck or other disability? Y ____ N ____

- Have you had bleeding problems or are you taking blood thinners? Y ____ N ____

- Are you pregnant or plan to become pregnant? Y ____ No ____

- Are you breastfeeding or plan to breastfeed? Y ____ No ____

- Are you allergic to any medications or latex? Y ____ No ____

- Please list all current medications both prescribed or non-prescribed, including vitamins, herbals, homeopathic, or other:

Signature

Date

DR/MA