

PATIENT INFORMATION AND MEDICAL HISTORY

Name _____ Date _____
Address _____ City _____ State _____ Zip _____
Home Phone _____ Work Phone _____ E-mail Address _____
Date of Birth _____ Age _____ Sex _____

HISTORY

Please check if you have or have had –

Diabetes	_____	Irregular menses	_____
Hepatitis	_____	Heart problems	_____
Herpes	_____	Hysterectomy	_____
Menopause	_____	Hypertension	_____
Sensitive to anesthetic	_____	Photosensitive Disorder	_____
Lupus	_____	Autoimmune illness	_____

Are you under the care of a physician? _____
Current/Recent medications _____

			<u>IF YES, EXPLAIN</u>
Keloid scars	Yes	No	_____
Hives	Yes	No	_____
Skin Cancer	Yes	No	_____
Waxing	Yes	No	_____
Electrolysis	Yes	No	_____
Cold Sores	Yes	No	_____
Hypersensitivity to skin products	Yes	No	_____
Skin Infections	Yes	No	_____
Tanning within the last 6 wks	Yes	No	_____
Use of acne products/drugs	Yes	No	_____
Laser skin resurfacing	Yes	No	_____
Chemical Peels	Yes	No	_____
Photo sensitizing substances	Yes	No	_____
Laser work of any type	Yes	No	_____

Medical Illness _____

Are you pregnant? _____

Allergies of any kind including drugs _____

Areas of interest for aesthetic treatment _____

Type of treatment requested Botox/ Filler _____

I ATTEST THE ABOVE INFORMATION TO BE TRUE, KNOWING MY PROVIDER RELIES ON THIS INFORMATION TO PROVIDE SAFE AND EFFECTIVE TREATMENT.

Patient Signature _____ Date _____