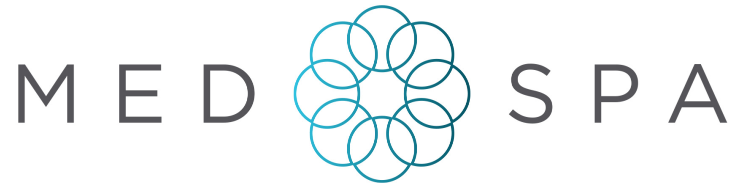

Client Medical History

Today's Date______________________

Name____

Date of Birth__________________________ Occupation_____________________________________

Home
Address____

City_______________________________ State________ Zip Code__________

Home Phone (_____) ________________ Cell Phone (______) ______________________

YES NO Do you smoke?
YES NO Regular Exercise? Type: ___________________________________

Email Address:

____

Emergency Contact Name and Phone:

____

Pharmacy Name/ Phone:

____

Whom should we thank for referring you?

____

Procedures / products of interest to you:

☐ BOTOX Cosmetic (Botulinum Toxin Type A)

☐ Dermal Fillers (Juvederm, Radiesse, Voluma, Sculptra)

☐ Skin Care Advice

☐ Skin Care Products

☐ Sunscreen Advice

☐ AHA and Glycolic Peels

☐ Chemical Peels

☐ Collagen Therapy

☐ Avage™, Retin-A or Renova

☐ Facials and Eye Treatments

☐ Skin Rejuvenation / SkinPen

☐ Micro-Dermabrasion

☐ Laser Treatments

☐ Laser Resurfacing

☐ Hair Removal

☐ Birthmarks

☐ Liver Spots/Age Spots

☐ Acne

☐ Spider Vein

☐ Rosacea / Facial Veins

☐ Other, please specify ____

History of Cosmetic/Aesthetic Procedures:

YES NO Have you ever had any facial surgery performed?
TYPE: ____________________

YES NO Have you ever had any type of Chemical Peel?
TYPE: _____________________

YES NO Have you ever had any type of laser treatment including laser hair removal?
TYPE: _____________________

YES NO Have you had any recent tanning or sun exposure that changed the color of your skin?
TYPE: _____________________

YES NO Have you recently used any self-tanning lotions or treatments?
TYPE: _____________________

Have you ever had any of the following injectable procedures done? (circle)

Botox Juvederm Restylane Radiesse Collagen Sculptra
Other_______________________

Fitzpatrick Skin Type: (circle one)

I Always burns, never tans
II Always burns, sometimes tans
III Sometimes burns, always tans
IV Rarely burns, always tans
V Brown, moderately pigmented Skin
VI Black skin

YES NO Are you currently under the care of a physician (for other than annual exams?)
If YES for what: ____

YES NO Are you currently under the care of a dermatologist?
If YES for what: ____

Do you have any of the following medical conditions?

☐ NONE

☐ Cancer ☐ Diabetes ☐ High blood pressure ☐ Herpes/cold sores ☐ Arthritis

☐ HIV/AIDS ☐ Skin disease ☐ Seizure Disorder ☐ Hepatitis ☐ Hormone Imbalance

☐ Any Active Infections ☐ Acne ☐ Rosacea ☐ Thyroid Imbalance

☐ Blood clotting/bleeding abnormalities

Do you have any other health problems or medical conditions (not listed)?

____

____

YES NO **Do you have any allergies to ANY medications?**
(Please list ALL & TYPE of reaction)

____

____

Please list ALL medications (including OTC / herbal supplements) you are currently taking.

☐ NONE ☐ Birth control pills ☐ Hormones ☐ Others (please list)

____

Please list all Topical Medications / Skin Care Creams you are currently taking.

____

YES NO **Are you currently using** ☐ Aspirin, ☐ NSAIDS (Motrin, Advil, Aleve),

☐ Plavix (clopidogrel), ☐ Coumadin (warfarin), ☐ Pradaxa, ☐ Eliquis, or

☐ Lovenox (heparin) ?

YES NO **Have you ever used Accutane (isotretinoin)?**
If yes, when did you last use? ______________________________

Do you have any of the following specific allergies?

YES NO Lidocaine/ Novocain?
YES NO Hydroquinone or skin bleaching agents?
YES NO Hypersensitivity to Latisse (Bimatoprost)?
YES NO Botulinum toxin (Botox) products?
YES NO Gram-positive bacterial proteins?
YES NO PLLA (dissolvable sutures)

If you circled "YES" to any of the above, please explain here:

____

Do you presently have or have you had a history of any of the following conditions?

YES NO Have any autoimmune disorders?
YES NO Any disease that affects muscles and nerves?
YES NO Amyotrophic lateral sclerosis [ALS or Lou Gehrig's disease]?
YES NO Myasthenia gravis / Lambert-Eaton syndrome?

YES NO Scleroderma or other connective tissue disease?
YES NO Are you on immunosuppressive therapy?
YES NO Have had radiation therapy?
YES NO Bleeding problems?
YES NO Breathing problems, such as asthma or emphysema?
YES NO Drooping eyelids? (other than natural aging)
YES NO Do you have history of any eye pressure problems / macular edema?
YES NO Have a pacemaker or internal defibrillator?
YES NO Herpes infections, bacterial or fungal infections in the areas to be treated?
YES NO History of epilepsy?
YES NO Side effects from any Botulinum toxin product in the past?
YES NO Do you form thick or raised scars (keloids) from cuts or burns?
YES NO Hyperpigmentation (darkening of the skin) or
Hypopigmentation (lightening of the skin)?
YES NO Areas of persistent redness?
YES NO Are you using medications that make you sensitive to light?
YES NO Are you using preparations containing sulfur, resorcinol, or salicylic acid?
YES NO Do you have a history of anaphylaxis/severe allergies?

Women only:

YES NO Are you using contraception?
YES NO Pregnant or plan to become pregnant?
YES NO Breast-feeding or plan to breastfeed?

If you circled "Yes" to any of the above, please explain here:

____

I certify that the preceding medical, personal and skin history statements are true and correct. I am aware that it is my responsibility to inform the aesthetician, therapist, nurse, or doctor of my current medical or health conditions and to update this history.

Patient Signature____ Date ____________

Reviewed with patient by____ Date ____________