Aesthetics Medical History Form

Name: _____ Date of Birth: _____ Gender: _____

Race/ Ethnicity: _____ Home Phone: _____ Cell Phone: _____

Email Address: _____ Marital Status: S M W D

Mailing Address: _____ City/State/Zip: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Emergency Contact/Relationship: _____ Phone: _____

Medical History

○ Cardiac Disease ○ Anemia/Bleeding Disorders ○ Hepatitis ○ Diabetes ○ Arthritis/Arthralgia ○ HIV/AIDS ○ Headaches/Epilepsy/Seizures ○ Bruising or Bleeding Disorders	○ Thyroid/Autoimmune ○ Unexplained Numbness/ Muscle Weakness ○ High Blood Pressure ○ Hernia/Hernia Repair ○ Cancer ○ Asthma ○ Lupus	○ Pacemaker ○ Permanent Metal Implant ○ Psoriasis ○ Nerve/Muscle Issues ○ Vitiligo ○ Body Piercings ○ Tattoos/Permanent Makeup

Other: _____

Skin Concerns - Please check all that apply.

○ Acne/Acne Scaring ○ Eczema ○ Melasma ○ Unwanted Body Hair ○ Clogged Pores ○ Hyperpigmentation	○ Brown Spots/Sun Damage ○ Rosacea ○ Large Pores ○ Skin Laxity ○ Dry/ Dehydrated Skin ○ Stretch Marks	○ Spider Veins ○ Fine Lines & Wrinkles ○ Skin Texture ○ Pigmented Lesions ○ Vellus Hair (Peach Fuzz) ○ Stubborn Fat

Other: _____

Which body area(s) or condition would you like treated? _____

_____

Please answer the following questions:

1. Do you have any current or chronic medical illnesses? **Yes** **No**
   Please List: _____
2. Do you have any current or chronic skin conditions? **Yes** **No**
   _____
3. Do you have any allergies to medications, foods, latex or other substances? **Yes** **No**
   Please List: _____
4. Do you smoke? **Yes** **No**
5. Do you consume alcohol? **Yes** **No**
6. Do you exercise regularly? **Yes** **No**
7. Do you get facials, chemical peels or microdermabrasions regularly? **Yes** **No**
   Which service/when: _____
8. Are you on any form of birth control? **Yes** **No** Please List: _____
9. Are you pregnant, currently trying to become pregnant, or breastfeeding? **Yes** **No**
   Please Explain: _____
10. Are menstrual periods regular, or have you ever been diagnosed with Polycystic Ovarian Disorder? **Yes** **No** Please Explain: _____
11. Are you currently under a doctor's care? **Yes** **No**
    a. For what reason? _____
12. Do you take/use any medications, vitamins or supplements on a regular basis? **Yes** **No**
    a. Please list: _____
13. Are there any topical products that you use on your skin on a regular basis? **Yes** **No**
    a. Please list: _____
14. Do you take/use any systemic/oral steroids? **Yes** **No**
15. Do you have a history of herpes I or II in the area to be treated (cold sores or blisters)? **Yes** **No**
16. Do you have any sexually transmitted diseases? **Yes** **No**
    Please List: _____
17. Do you have a history of keloid scarring or hypertrophic scar formation? **Yes** **No**
18. Do you have a history of light induced seizures? **Yes** **No**
19. Do you have open scars or lesions? **Yes** **No**
20. Do you have history of radiation therapy in the area to be treated? **Yes** **No**
21. Do you have any unusual reactions or problems with topical anesthesia creams? **Yes** **No**
    Please Explain: _____
22. In the last six (6) months, have you used any of the following:
    a. Anticoagulants or blood thinning medications
    b. Photosynthesizing medications
    c. Anti-inflammatory medications

Please list and last date used: _____

23. In the last (1) month, have you used any of the following products:
    a. Glycolic acid or other alphahydroxy or betahydroxyl acid products or chemical peels?
    b. Exfoliating or resurfacing products or facial treatments?

    Please list and last date used: _____

24. Do you have or have you ever had any permanent makeup, tattoos, implants or fillers, including but not limited to, collagen, autologous fat, Restylane, etc?
    Please list where and last date used: _____
    _____
25. Do you have or have you had any Botulinums, such as Botox, Dysport, or fillers?

Please list where and last date used: _____

26. Have you taken Accutane (or products containing Isotretinoin) in the last 12 months? **Yes** **No**
    Please Explain: _____
27. Have your taken tretinoin or used (like Retin-A, Renova) in the last six months? **Yes** **No**
28. Have you ever had a problem, when having your blood drawn? **Yes** **No**
29. Do you think you sweat more than normal or are you an excessive sweater? **Yes** **No**
30. Do you have a history of fainting passing out? **Yes** **No**
31. Do you consider yourself to have an anxious or nervous personality? **Yes** **No**
32. Have you ever been diagnosed with anxiety disorder? **Yes** **No**
33. Have you had any unprotected sun exposure, used tanning creams (including sunless tanning lotions) or tanning beds or lamps in the last two weeks? **Yes** **No**

I have answered the questions to the best of my knowledge. I understand it is my responsibility to inform the office of my current health conditions while seeking treatment as a patient. I will update this information as it occurs if there are any changes to my health during or in between treatments,

Signature: _____ Date: _____