**PATIENT MEDICAL HISTORY FORM**

**Please print information clearly below. Let us know if you have any questions.**

|  |  |
| --- | --- |
| Last Name: | First Name: |
| Date of Birth: | Gender: |
| Height: Weight: | Physician Name: |
| Pharmacy: | Pharmacy Phone: |

**Reason(s) for Consultation:**

|  |
| --- |
|  |
|  |
|  |

**COSMETIC HISTORY (Please check any Procedure that may apply to you):**

|  |  |  |  |
| --- | --- | --- | --- |
|  | Face lift |  | Lips |
|  | Eyelid lift |  | Fillers (name): |
|  | Rhinoplasty |  | Neuromodulators: (Botox, Dysport, Xeomin) |
|  | Breast Surgery |  | Tattoo or permanent makeup |

|  |  |  |  |
| --- | --- | --- | --- |
|  | JOINT SURGERY (hip / knee) |  | Hernia repair |
|  | Diabetes |  | Heart disease |
|  | High blood pressure |  | Autoimmune disorders (like Lupus) |
|  | Lung disease or asthma |  | Seizures |
|  | Anemia or blood disorders |  | HIV infection |
|  | Stroke (when) |  | Hepatitis |
|  | Cancer within the last 5 years |  | Psychiatric disorders |
|  | Blood disorders |  | Metal plates, implants or devices |
|  | Pacemaker or defibrillator |  | History of radiation treatment |
|  | Renal failure |  |  |
|  | Abdominal or colon surgery |  |  |

**MEDICAL HISTORY (Please check any medical conditions that may apply to you):**

**Have you ever been diagnosed with any of the following skin conditions?**

|  |  |  |  |
| --- | --- | --- | --- |
|  | Heat urticaria or hives |  | Diseases of the collagen |
|  | Vitiligo |  | Herpes/cold sores/fever blisters |
|  | Eczema |  | Skin cancer |
|  | Psoriasis |  | Sensitivity or allergy to the sun |
|  | Melasma |  | Abnormal scarring |

**Current Medications (Prescription, Over the Counter, Vitamins & Supplements):**

|  |  |  |
| --- | --- | --- |
|  |  |  |
|  |  |  |
|  |  |  |

**Drug Allergies/Adverse Reactions:**

|  |  |  |
| --- | --- | --- |
|  |  |  |

**Have you taken any of the following medications in the last 6 months? (please circle)**

Doxycycline Minocycline Tetracycline Blood Thinners Aspirin

Birth Control Accutane (or similar pill) Retin A Tretinoin

|  |  |  |
| --- | --- | --- |
| Have you smoked in the past year? | Yes | No |
| Do you use any other tobacco products? | Yes | No |
| Do you drink alcoholic beverages?  How often? Daily Weekly Monthly Weekend only | Yes | No |
| Have you used any tanning beds, lamps or products in the last 6 weeks? | Yes | No |
| Do you have any permanent make-up or tattoos in area to be treated? | Yes | No |

**Women Only:**

|  |  |  |
| --- | --- | --- |
| Are you pregnant or nursing? | Yes | No |
| Do you have a history of Polycystic Ovarian Syndrome? | Yes | No |

Anything else we should know about you?

I certify that the information provided on this medical history is correct and complete. Further, I understand that providing incomplete and incorrect information may not only jeopardize my health, but also render ineffective or harmful, any treatment I receive from Favia MediSpa.

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_