CLINIC INFORMATION & MEDICAL HISTORY

In order to provide you with the most appropriate cosmetic treatment, we need to complete the following questionnaire. All information is strictly confidential.

PERSONAL HISTORY

Name______________________________Email:________________________________Date________________

Street Address____

City:_____________________________ State___________________ Zip Code:___________________

Phone number for appointment/reminder/messages: ( )________________________

Do you consent to texting with our office or office employees? **Yes No**

Emergency Contact Name and Number: _______________________________________

Would you like to be included in our home mailer? **Yes No**

Is it ok if we email you with our Specials? **Yes No**
Do you consent to texting with our office or office employees? **Yes No**

Number to send text messages ( )____

How did you hear about us? ____

MEDICAL HISTORY

Birth Month/ Day/ Year: _____________ Are you currently under the care of a physician? **Yes No**

If yes, for what?________________________ Who is your Primary M.D.?_____________________________

What medication(s) are you currently taking?____

Any known drug allergies? **Yes No** Please list:_________________________________

Have you ever had a skin allergy? ____

Do you have a skin allergy to gram-positive bacterial proteins? **Yes No**

Do you have a history of Keloid scarring? **Yes No** Have you had previous cosmetic injections? **Yes No**

If yes, what product? Restylane Botox Collagen Juvederm Radiesse Sculptra

When was the last time you had the injection? ___________________

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Are you allergic to egg or egg products? **Yes No**

Do you take blood thinners? **Yes No**

If yes, what kind: ____

Have you ever had an allergic reaction to any of the following? (Please circle all that apply)

Food Aspirin Lidocaine Hydrocortisone Bee Stings Hydroquinone Pumpkin

Please list all allergies: ____

What oral medications are you currently taking? ____

What herbal supplements do you use regularly?____

Have you ever had a reaction or complication from numbing at the dentist? **Yes No**

Are you using Retin A, Hydroquinone (Bleaching Cream), Glycolic Acid, Accutane or any medication that could cause sun sensitivity? **Yes No**

If you have taken Accutane when did you last use it? ____________________________

Have you recently had a peel (chemical, acid, fruit, microdermabrasion)? **Yes No**

Have you recently used any self-tanning lotions or treatments? **Yes No**

Have you ever had laser hair removal? **Yes No**

Have you used any of the following hair removal methods in the past six weeks? (Circle all that apply)

Waxing Electrolysis Tweezing Threading Depilatories

Have you had any laser or photo facial treatments? **Yes No When**?_______________

Have you ever had a cold sore/herpes virus? **Yes No** If so when?_________________

Could you be pregnant? **Yes No** Are you breast-feeding? **Yes No**

Do you have a history or diagnosis of Auto Immune Disorder, Numbing of Extremities, Diabetes, or Seizure Disorder, cardiac history, or pacemaker implant? **Yes No**

Do you have Hyperpigmentation (darkening of the skin) or Hypopigmentation (lightening of the skin) or marks after physical trauma? **Yes No**

Do you have permanent cosmetic tattoos? **Yes No**

If so, where? Eyebrows? Eyeliner? Lip Liner Beauty Mark Enhancement

Do you have any freckles, moles or skin condition that has caused concern? **Yes No**

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 doctor or the nurse of my current medical or health conditions and to update this history with each appointment. A current medical history is essential for the caregiver to execute appropriate treatment procedures.

Cancellation Policy:

In addition, I am aware that a 24-hour cancellation policy exists. If I do not cancel my appointment within the time frame I agree to pay a missed appointment fee of $50.00.

Signature:______________________________________ Date:______________________

Practitioner:________________________________ Date:______________________

Office use only Skin Type:

Alternative Methods Discussed:

Allergies: Photograph Documentation:

Contraindications:

Copy to: patient chart

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