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______________________________ Birth Month/ Day/ Year: ____________ 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**

Email:________________________________
Is it ok if we email you with our Specials? **Yes** **No**

Emergency Contact Name and Number: _______________________________________

How did you hear about us? ____

MEDICAL HISTORY

Are you currently under the care of a physician? **Yes** **No**

If yes, for what?_______________________ Who is your Primary M.D.?____________________________

Please list medication(s) and/or herbal supplements that are you currently taking

____

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

If yes, what kind: ____

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

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

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**

Any known allergies (drug, skin, food,etc.) ? **Yes** **No**
If so, please list:____

Have you ever had a skin allergy? ____

CONFIDENTIAL

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

PREVIOUS TREATMENT HISTORY

Have you had previous cosmetic injections? **Yes** **No**

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

When was the last time you had the injection? ___________________

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** If so, **when**?_______________

Do you have a history of Keloid scarring? **Yes** **No**

Please List the Skincare Products you are Currently Using:

____

____

____

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