PATIENT INFORMATION AND MEDICAL HISTORY

Name____ Date______________

Address______________________________________City_________________ State_____Zip_______

Home Phone____________________ Work Phone________________E-mail Address____________________

Date of Birth_________________ Age____________ Sex______________

Emergency Contact Name: _______________________________________ Relationship to you: ___________________

Emergency Contact Phone Number: ___________________________________

HISTORY

Please check if you have or have had –

Diabetes	Irregular menses	Excessive Scarring/Keloid
Hepatitis	Heart problems	Allergy to lidocaine
Herpes	Hysterectomy	Eaton-Lambert Syndrome
Menopause	Hypertension	Myasthenia Gravis
Sensitive to anesthetic	Photosensitive Disorder	Amyotrophic Lateral Sclerosis (ALS)
Lupus	Autoimmune illness	Allergy to Saline, Eggs, or Human Albumin

Are you under the care of a physician? ____
Current/Recent medications ____
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			IF YES, EXPLAIN
Keloid scars	Yes	No	________________________________
Hives	Yes	No	________________________________
Skin Cancer	Yes	No	________________________________
Waxing	Yes	No	________________________________
Electrolysis	Yes	No	________________________________
Cold Sores	Yes	No	________________________________
Hypersensitivity to skin products	Yes	No	________________________________
Skin Infections	Yes	No	________________________________
Tanning within the last 6 wks	Yes	No	________________________________
Use of acne products/drugs	Yes	No	________________________________
Laser skin resurfacing	Yes	No	________________________________
Chemical Peels	Yes	No	________________________________
Photo sensitizing substances	Yes	No	________________________________
Laser work of any type	Yes	No	________________________________

Medical Illness____

Are you pregnant? ____

Allergies of any kind including drugs____

Areas of interest for aesthetic treatment____

Requested Area of Treatment:

BOTOX	Filler
Frown lines (between the eyes)	Lip Augmentation
Horizontal forehead lines	Nasolabial folds
Crow's Feet	Marionette Lines
Bunny lines (bridge of nose)	Vertical lip lines
Droopy Eyebrow	Scar fill-in
Lip Flip	

I ATTEST THE ABOVE INFORMATION TO BE TRUE, KNOWING MY PROVIDER RELIES ON THIS INFORMATION TO PROVIDE SAFE AND EFFECTIVE TREATMENT.

Patient Signature____ Date ______________