AESTHETIC MEDICAL HISTORY FORM (PAGE 1/2)

Last Name:_____ First Name: _____ Initial:____
Date of Birth: ____ /____ /_____ Male ___ Female ___
Mailing Address: _____
City: _____ State: _____ Zip Code: _____
Email: _____ Mobile: _____OK to TEXT? Y/N
Home Phone: _____ Work Phone: _____
Family Doctor: _____ Pharmacy: _____
Emergency Contact: _____ Phone: _____
How did you find out about us? _____
Which body area(s) or condition would you like treated? _____
_____

Please answer each of the following questions:

1. Do you have ANY allergies to medications, foods, latex, or other substances? *Please List:* _____

2. Do you smoke? YES / NO Average per day? _____
   Do you consume alcohol? YES / NO Average per day? _____

3. Do you have ANY current or chronic medical conditions? YES / NO
   Disclose any history of heat urticaria, diabetes, autoimmune disorder or any immunosuppression, blood disorders, cancer, bacterial or viral infections, medical conditions that significantly compromise the healing response, skin photosensitivity disorders, or any other condition or illness.
   Please List: _____

4. Do you have ANY current or chronic skin conditions? YES / NO
   Also disclose any history of vitiligo, eczema, melasma, psoriasis, allergic dermatitis, any diseases affecting collagen including Ehlers-Danlos syndrome, scleroderma, skin cancer, or any other skin condition. Please List: _____

5. Are you under a doctor's care? YES / NO
   If so, for what? _____

6. Do you take ANY medications (prescriptions or non-prescriptions) including vitamins and herbal supplements on a regular basis? *Please List:*_____
   _____

7. Are there any topical products (both medical and non-medical) that you use on your skin on a regular or daily basis? YES / NO
   Please List: _____

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8. Are you taking oral steroids (eg. prednisone, dexamethasone)? YES / NO
9. Do you have a pacemaker or external defibrillator? YES / NO
10. Do you have any metal implants under the area being treated? YES / NO
11. Do you have a history of light-induced seizures? YES / NO
12. Do you have a history of Herpes in the area being treated? YES / NO
13. Do you have any open sores or lesions? YES / NO
14. Have you had radiation therapy in the area being treated? YES / NO
15. Do you have a history of keloid scaring or hypertrophic scar formation? YES / NO

16. In the last 6 months, have you used any of the following? Anticoagulants or blood-thinning medications, photosensitizing medications or anti-inflammatories? YES / NO
List Product, Date Used: _____

17. In the last 3 months, have you used any of the following products: glycolic acid or other alphahydroxy- or betahydroxyacid products, exfoliating or resurfacing products or treatments? YES / NO
List Product, Date Used: _____

18. Have you had any cosmetic procedures in the past 6 months? YES / NO
Please Describe: _____

19. Have you had any permanent make-up, tattoos, implants, or fillers, including but not limited to collagen, autologous fat, Restylane, ect.?
If yes, please list locations and dates: _____

20. In the last month, have you been treated with any Botulinums (eg. Botox or Dysport)? *If yes, please list:* _____ YES / NO

21. Have you taken Accutane (or products containing isotretinoin) or Tretinoin (eg. Retin-A, Renova) in the last 6 months? YES / NO

22. Have you had any unprotected sun exposure, used tanning creams (including sunless tanning lotions) or tanning beds/lamps in the last month? YES / NO

For Women Only:

23. Are you pregnant or breastfeeding? YES / NO
24. Are your menstrual periods regular? YES / NO
25. Have you been diagnosed with Polycystic Ovarian Disorder? YES / NO

Signature: _____ Date: _____
Reviewed by: _____ Date: _____