PATIENT INFORMATION AND MEDICAL HISTORY

Name______________________________ Date______________

Address______________________________ City______________ State____ Zip______

Home Phone______________ Work Phone______________ E-mail Address______________

Date of Birth______________ Age__________ Sex______________

HISTORY

Please check if you have or have had –

Diabetes __________
Hepatitis __________
Herpes __________
Menopause __________
Sensitive to anesthetic __________
Lupus __________

Irregular menses __________
Heart problems __________
Hysterectomy __________
Hypertension __________
Photosensitive Disorder __________
Autoimmune illness __________

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

Frown lines (between the eyes)______________
Horizontal forehead lines______________
Crow's Feet______________
Bunny lines (bridge of nose)______________
Droopy Eyebrow______________

Filler

Lip Augmentation______________
Nasolabial folds______________
Marionette Lines______________
Vertical lip lines______________
Scar fill-in______________

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

Patient Signature______________________________ Date ______________