



Medical History & Questionnaire

Name: _____ Age: _____ Date of Birth: ___/___/___ Gender: M F
Address: _____ City: _____ State: _____ Zip: _____
Telephone: Home: _____ Work: _____ Cell: _____
E-mail: _____ How did you hear about us? _____
In case of emergency, whom should we contact? _____ Phone: _____

Medical History

Have you ever had (please check all that apply):

- | | | |
|--|---|--|
| <input type="checkbox"/> Heart disease/Heart attack | <input type="checkbox"/> Diabetes | <input type="checkbox"/> History of Cancer |
| <input type="checkbox"/> Chronic skin conditions | <input type="checkbox"/> Lupus | <input type="checkbox"/> HIV or AIDS |
| <input type="checkbox"/> Endocrine or hormone disorder | <input type="checkbox"/> Hypertension | <input type="checkbox"/> Epilepsy |
| <input type="checkbox"/> Planning, current or recent pregnancy | <input type="checkbox"/> Heart pacemaker or defibrillator | <input type="checkbox"/> Hepatitis |

List any active medical problems you have: _____

List any medications you currently take: _____

List any medication allergies you have: _____

Are you allergic to any numbing agents? _____ Are you allergic to latex? _____ Smoke? _____

Surgical History

List any operations you have had within a year:

- | | | |
|----------|----------|----------|
| 1. _____ | 3. _____ | 5. _____ |
| 2. _____ | 4. _____ | 6. _____ |

Dermatological History (For Botox and Laser patients only)

Have you ever has (please check all that apply):

- | | | |
|--|---|---|
| <input type="checkbox"/> Varicose or spider veins | <input type="checkbox"/> Self tanner | <input type="checkbox"/> Laser skin resurfacing |
| <input type="checkbox"/> Photosensitivity | <input type="checkbox"/> Herpes simplex or cold sores | <input type="checkbox"/> Chemical peel |
| <input type="checkbox"/> Keloid or hypertrophic scar | <input type="checkbox"/> Accutane use for acne | <input type="checkbox"/> Botox, Dysport or Xeomin injection |
| <input type="checkbox"/> Pigmentation disorder | <input type="checkbox"/> Antibiotic use regularly | <input type="checkbox"/> Injection of collagen or other dermal filler |
| <input type="checkbox"/> Recent waxing or plucking | <input type="checkbox"/> Electrolysis or threading | <input type="checkbox"/> Recent sunburn or tan (include tanning bed) |

What is your ethnic background? _____

When exposed to the sun, do you usually: Always burn, never tan burn easily, tan poorly Tan after initial burn Burn minimally, tan easily Rarely burn, tan dark easily never burn, always tan dark

List any special skincare products you use including a retin-a, retinol anti-aging products:

Client Signature: _____ Date: _____

Parent or Guardian (is patient is under 18 years of age): _____