



PATIENT INFORMATION AND MEDICAL HISTORY

Name _____ Date _____
 Address _____ City _____ State _____ Zip _____
 Home Phone _____ Work Phone _____ E-Mail _____
 Date of Birth _____ Age _____ Sex _____

Medical History

Please check if you have or have had-

Diabetes _____	Irregular menses _____
Hepatitis _____	Heart Problems _____
Herpes _____	Hysterectomy _____
Menopause _____	Hypertension _____
Sensitive to anesthetic _____	Photosensitive Disorder _____
Lupus _____	Autoimmune Illness _____

Are you under the care of a physician? _____

Current/Recent Medication: including Nsaids, Fish Oil, Coumadin _____

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 _____

Area 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 _____