PATIENT INFORMATION AND MEDICAL HISTORY

Name_____ Date_____

Address_____ ,Unit/Apt #_____

City_____ State_____ Zip_____

Date of Birth_____Phone (hm) _____(cell)_____

Age_____ Sex_____ Email_____

Emergency Contact_____Phone_____

HISTORY

Please check if you have or have had the any of the following:

_____Diabetes
_____Hepatitis
_____Herpes
_____Heart Problems
_____Autoimmune Disease
_____Hypertension
_____Irregular Menses
_____Hysterectomy
_____Menopause
_____Anesthetic sensitivity
_____Lupus
_____Photosensitive Disorder

YES or NO			If Yes, Explain:
Yes	No	Keloid Scarring	_____
Yes	No	Hives	_____
Yes	No	Skin Cancer	_____
Yes	No	Cold Sores	_____
Yes	No	Skin Infections	_____
Yes	No	Hypersensitivity to skin products	_____
Yes	No	Tanning within the last 6 weeks	_____
Yes	No	Use of acne products/drugs	_____
Yes	No	Photo sensitizing substances	_____
Yes	No	Laser work of any type	_____
Yes	No	Laser skin resurfacing	_____
Yes	No	Waxing	_____
Yes	No	Electrolysis	_____
Yes	No	Chemical peels	_____
Yes	No	Are you currently pregnant?	Last Menstral Period:_____
Yes	No	Are you under the care of a physician?	_____

Medical Illness_____

Current Medications_____

_____

Allergies to food, drugs, etc._____

_____

Requested Areas of Treatment

BOTOX/XEOMIN

___Frownlines (between eyes/brows)
___Horizontal forehead lines
___Crow's feet
___Bunny lines (bridge of nose)
___Droopy eyebrow(s) ___Other_____

FILLER

___Lip Augmentation
___Nasolabial folds
___Marionette lines
___Vertical Lip lines
___Scar fill-in ___Other_____

I attest the above information to be true, knowing my provider/nurse relies on this information for safe and effective treatment.

Patient Signature:_____ Date_____