

## **MEDICAL HISTORY FORM**

DATE: \_\_\_\_\_

BIRTHDATE: \_\_\_\_\_

NAME: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

PHONE #: \_\_\_\_\_ EMAIL: \_\_\_\_\_

EMERGENCY CONTACT PERSON: \_\_\_\_\_ PHONE #: \_\_\_\_\_

PRIMARY CARE PROVIDER: \_\_\_\_\_ PHONE#: \_\_\_\_\_

DO YOU PRESENTLY HAVE OR PREVIOUSLY HAD ANY OF THE FOLLOWING: (CIRCLE YES OR NO)

YES NO BOTOX

YES NO DIABETES

YES NO LIP FILLERS/RESTYLANE/JUVEDERM

YES NO COLD SORES/FEVER BLISTERS EVER?

YES NO BLEPHAROPLASTY (EYELID SURGERY)

YES NO HEPATITITS (A,B,C,D)

YES NO BROW LIFT

YES NO EASY BLEEDING

YES NO FACELIFT

YES NO ALCOHOLISM

YES NO EYE SURGURGY/ INJURY/ CORNEAL ABRASION

YES NO ABNORMAL HEART CONDITION

YES NO CONTACT LENSES NOW

YES NO CHEMICAL PEEL (LAST TREATMENT: \_\_\_\_\_ )

YES NO PREGNANT NOW/BREAST FEEDING NOW

YES NO BROW OR LASH TINTING

YES NO OILY SKIN

YES NO ACCUTANE OR ACNE TREATMENT

YES NO TANNING BY BOOTH OR NATURAL SUN

YES NO DIFFICULTY NUMBING WITH DENTAL WORK

YES NO TAKING BLOOD THINNERS SUCH AS: ASPIRIN, IBUPROFEN, ALCOHOL, COUMADIN, ECT: \_\_\_\_\_

YES NO ALLERGIC REACTION TO ANY MEDICATIONS SUCH AS LIDOCAINE, BENZYL ALCOHOL, VITAMIN E ACETATE, ECT.

LIST: \_\_\_\_\_

YES NO ALLERGIES TO METALS, FOOD, ECT: \_\_\_\_\_

YES NO ANY DISEASES OR DISORDERS NOT LISTED: \_\_\_\_\_

YES NO DO YOU USE SKIN CARE PRODUCTS CONTAINING RETIN-A, GLYCOLIC ACID OR ALPHA HYDROXYL?

PLEASE LIST ALL MEDICATIONS OR VITAMINS YOU'RE PRESENTLY TAKING: \_\_\_\_\_

\_\_\_\_\_  
**I AGREE THAT ALL THE ABOVE INFORMATION IS TRUE AND ACCURATE TO THE BEST OF MY KNOWLEDGE.**

**SIGNATURE:** \_\_\_\_\_ **DATE:** \_\_\_\_\_