Aesthetic Medical History

Name:______________________________ **Date of Birth:**__________

PLEASE COMPLETE THE FOLLOWING (STRICTLY CONFIDENTIAL):

Food Allergies: __ Yes __ No If Yes, Please list______________________

Drug Allergies: __ Yes __ No If Yes, Please list______________________

How would you rate your general health? Excellent Good Fair Poor

Would you object to our office contacting your family doctor in regard to any medical problem that may arise? __________

Please list ALL medications (including over the counter medications/vitamins you currently take daily or on an as needed basis):

______________ ______________ ______________

______________ ______________ ______________

Prior Surgeries or hospitalizations:

	When?		When?
	When?		When?

Please indicate if you have any of the following medical problems and when:

Have you ever received **local** anesthesia (Novocaine or Xylocaine) by a dentist or doctor?	Yes No
Have you ever received **general** anesthesia?	Yes No
Have you ever had any adverse reaction to either local or general anesthesia?	Yes No
Do you take blood thinners?	Yes No
Do you exercise regularly?	Yes No
Are you a keloid former?	Yes No

Have you had:

Blood pressure or related problems	Yes No	Any medical treatment for nervous condition	Yes No
Liver, gall bladder problems	Yes No	Excessive scarring	Yes No
"Yellow Jaundice", Hepatitis problems	Yes No	Tuberculosis	Yes No
Heart trouble	Yes No	Thyroid problems	Yes No
Kidney disease	Yes No	History of blood clots in legs or lungs	Yes No
Diabetes	Yes No	History of leg swelling	Yes No
Bleeding tendency or excessive bleeding	Yes No	Glaucoma, cataracts	Yes No
Any part of your body paralyzed or numb	Yes No	Dry eyes	Yes No
Psychiatric consultation	Yes No	Genital herpes or cold sores	Yes No
Epilepsy-convulsions or seizures	Yes No	Gain or loss of more than five pounds in body weight in the last 3 months	Yes No
Broken bones of the face, neck, jaw, back	Yes No		
Abnormal Electrocardiogram (ECG)	Yes No	Any other illness. If so please list:	Yes No
Asthma or other respiratory problems	Yes No		

Do you:

Wear contact lenses	Yes No	
Smoke?	Yes No	How much?
Drink Alcohol?	Yes No	How much?
Think you are pregnant?	Yes No	Date of last menstrual period?
Have any contagious or infectious condition	Yes No	
Have you been exposed directly or indirectly to anyone with HIV (AIDS)	Yes No	

Please list any previous or current skin care products:

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Have you ever had Botox, fillers, chemical peels microderm abrasion or facial surgeries? Yes No

If so, any problems?

*****The above information is strictly confidential*****

______________________________ ______________

Patient Signature **Date**