

MEDICAL HISTORY

Name _____ Address _____
 City _____ State _____ Zip _____ Email _____
 Home Phone _____ Work/Cell Phone _____
 Primary Physician's Name _____ Phone # _____
 DOB _____ Age _____ Height _____ Weight _____

Please list all medications/vitamins you are currently taking: _____

Allergies: _____ Are you on Antibiotics at this time? _____

Do you have any of the following conditions? (Check Yes or No)

- | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|---|--------------------------|--|--|--------------------------|--------------------------|-------------------------|--------------------------|--------------------------|----------------------------|--------------------------|--------------------------|--------------------------------|--------------------------|--------------------------|--|--------------------------|--------------------------|---------------------------------|--------------------------|--------------------------|--------------------------------|--|------------|-----------|--|--------------------------|--------------------------|----------|--------------------------|--------------------------|----------------------|--------------------------|--------------------------|--------------------|--------------------------|--------------------------|-------------------------|--------------------------|--------------------------|---------------------|
| <table border="0"> <tr> <td style="width: 50px;">YES</td> <td style="width: 50px;">NO</td> <td></td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Cold Sores, when? _____</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Dry Eye - Use Drops? _____</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Abnormal Heart Condition _____</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>High / Low Blood Pressure (Circle) _____</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Fainting or Dizzy Spells? _____</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Prolonged Bleeding- why? _____</td> </tr> </table> | YES | NO | | <input type="checkbox"/> | <input type="checkbox"/> | Cold Sores, when? _____ | <input type="checkbox"/> | <input type="checkbox"/> | Dry Eye - Use Drops? _____ | <input type="checkbox"/> | <input type="checkbox"/> | Abnormal Heart Condition _____ | <input type="checkbox"/> | <input type="checkbox"/> | High / Low Blood Pressure (Circle) _____ | <input type="checkbox"/> | <input type="checkbox"/> | Fainting or Dizzy Spells? _____ | <input type="checkbox"/> | <input type="checkbox"/> | Prolonged Bleeding- why? _____ | <table border="0"> <tr> <td style="width: 50px;">YES</td> <td style="width: 50px;">NO</td> <td></td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Diabetes</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Use Tobacco Products</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Cosmetic Surgeries</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Facial Cosmetic Surgery</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Pregnant or Nursing</td> </tr> </table> | YES | NO | | <input type="checkbox"/> | <input type="checkbox"/> | Diabetes | <input type="checkbox"/> | <input type="checkbox"/> | Use Tobacco Products | <input type="checkbox"/> | <input type="checkbox"/> | Cosmetic Surgeries | <input type="checkbox"/> | <input type="checkbox"/> | Facial Cosmetic Surgery | <input type="checkbox"/> | <input type="checkbox"/> | Pregnant or Nursing |
| YES | NO | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | Cold Sores, when? _____ | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | Dry Eye - Use Drops? _____ | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | Abnormal Heart Condition _____ | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | High / Low Blood Pressure (Circle) _____ | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | Fainting or Dizzy Spells? _____ | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | Prolonged Bleeding- why? _____ | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| YES | NO | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | Diabetes | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | Use Tobacco Products | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | Cosmetic Surgeries | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | Facial Cosmetic Surgery | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | Pregnant or Nursing | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

List and/or Explain Other Medical Conditions not listed above: _____

Have you had Plastic Surgery or other surgery to your face/neck areas? If so, when? _____

Have you had any type of Laser, Botox, Dermal Fillers (Restylane, Radiesse, Sculptra, Juvederm), performed on your face or have scheduled in the future? If so, which procedure(s)? Where on your face? When performed or scheduled?

Were you pleased with your result(s)? Any complications/concerns? _____

How did you hear about us? _____

I understand the information on this form is essential to determine my medical and cosmetic needs and the provision of treatment. I understand that if any changes occur in my medical history/health I will report it to the office as soon as possible. I have read and understand the above medical history questionnaire. I acknowledge that all answers have been recorded truthfully and will not hold any staff member responsible for any errors or omissions that I have made in the completion of this form.

Patient Signature _____ Date _____