Medical History Form

Name: _____ Date: _____

Address:_____City/State/Zip:_____

Home phone:_____ Cell phone:_____

Email address:_____ DOB: _____ Age:_____

Referred by: Doctor_____ Friend: _____Other (list):_____

Employer:_____ Profession:_____

Daily Medications including herbs:_____

Current skin care products:_____

General (please circle any that apply)

Allergies_____
- Cold Sores/Shingles/Herpes
- Pacemaker/Metal Implant
- Diabetes
- Heart Disease
- High/Low Blood Pressure
- Allergy Lidocaine
- Asthma/Difficulty breathing
- HIV/AIDS
- Depression
- Thyroid disorder
- Seizures
- Neck/Back Pain
- Allergy Epinephrine
- Skin or Nail Infections
- Smoker
- Anxiety/Panic
- Kidney Disease
- Fibromyalgia
- Neuro-muscular disease

Other (list):_____

Other (please circle any that apply)

- Excess pigment/freckles
- Thick or keloid scars
- Acne/cystic acne
- Rosecea
- Lack of pigment
- Skin reaction to treatments
- Skin cancer
- Broken capillaries
- Eczema, psoriasis or rashes
- Melasma/Mask of pregnancy
- Accutane when:_____

Previous Treatments (please circle any that you have had)

- Botox/Dysport
- Radiesse
- Intense Pulsed Light
- Permanent make-up
- Restylane/Perlane
- Other fillers
- Laser/light treatment
- Retin-A/Renova Use
- Juvederm
- Chemical Peel
- Microdermabrasion
- Thermage

Fitzpatrick Skin Typing: Please select the description that best explains the way your skin responds to the sun after 15 minutes of unprotected exposure:

- ☐ Always burns, never tans (Type One)
- ☐ Always burns, uneven tan & freckles (Type Two)
- ☐ Sometimes burns, always tans (Type Three)
- ☐ Rarely burns, always tans (Type Four)
- ☐ Never burns, deeper tan (Type Five)
- ☐ Never burns, increased tan (Type Six)

Date of recent sun tanning or tanning beds:_____ Use of self tanner: yes/no

Check the following treatments you are interested in knowing more about:

- ☐ Fillers
- ☐ Facials
- ☐ Vein Removal
- ☐ Thermage
- ☐ Botox/Dysport
- ☐ Make-up
- ☐ Products
- ☐ Pixel
- ☐ Hair removal
- ☐ Chemical Peels
- ☐ Waxing
- ☐ Microdermabrasion
- ☐ Massage
- ☐ Intense Pulsed Light
- ☐ Fitness/Weight Management
- ☐ Cosmetic Surgery

Exilis

Coolsculpting

Check the following conditions that you would like to correct:

- ☐ Dryness
- ☐ Irritated Skin
- ☐ Enlarged Pores
- ☐ Sagging skin
- ☐ Aging
- ☐ Sensitive Skin
- ☐ Acne
- ☐ Other:_____
- ☐ Spots/sunspots
- ☐ Melasma
- ☐ Oily Skin
- ☐ Rosacea
- ☐ Rough Skin Texture
- ☐ Wrinkles

Name:
Signature:
Date: