PHI CLINIC

Aesthetic Medical History

Ernesto Padron, MD

Name: Date of Birth:

PLEASE COMPLETE THE FOLLOWING (STRICTLY CONFIDENTIAL):

Allergic Reactions (foods, medications, bee stings, etc.): __Yes __No

Please list:

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

Would you mind if our office contacted your primary care physician in case a medical issue arises?

Please list ALL medications you are taking (including over-the-counter medications/vitamins you currently take daily or as needed):

Surgeries or previous hospitalizations. __Yes __No When?

Recent or upcoming dental treatment __Yes __No

Facial trauma __Yes __No

Recent vaccinations or immunizations __Yes __No

Indicate if you have had any of the following medical problems and when:

Have you received local anesthesia (Novocain or Xylocaine) from a dentist or physician? __Yes __No

Have you ever received general anesthesia? __Yes __No

Have you had any adverse reactions to local or general anesthesia? __Yes __No

Are you taking blood thinners? __Yes __No

Do you exercise regularly? __Yes __No

Do you form keloids in scars? __Yes __No

Do you have or suffer from skin diseases (Acne, Rosacea, Dermatitis)? __Yes __No

Do you have skin pigmentation problems? __Yes __No

Have you had any of the following conditions?

CONDITION	YES	NO	CONDITION	YES	NO
High blood pressure			Myasthenia / neurological condition		
Heart problems Yes No			Excessive scarring		
Abnormal Electrocardiogram			Tuberculosis		
Liver or gallbladder problems			Thyroid problems		
Kidney disease			Blood clots in legs or lungs		
Diabetes			Leg swelling		
Bleed easily			Glaucoma or cataracts		
Numbness or paralysis in any body part			Psychiatric problems		
Genital or oral herpes			Epilepsy or seizures		
Loss or gain of more than 5 pounds in the last 3 months			Fractures to face, jaw, neck, back		
Any other disease:			Asthma or other respiratory problems		
Which?					

PHI CLINIC

Aesthetic Medical History **(Continuation, pag. 2)**

Name: Date of Birth:

Are you currently pregnant or breastfeeding? __Yes __No

Date of last Menstruation:

Do you smoke? __Yes __No If so, how many per day?

Do you consume alcohol? __Yes ___No If so, how often?

Do you have Dry eyes? __Yes __No Do you use contact lenses? __Yes __No

Any infection or contagious disease? __Yes __No

List previous or current skin care products used:

Have you ever had treatment with BOTOX, Fillers, Chemical Peel, Microdermabrasion, or Facial Surgery? ___Yes __ No

If yes, When _____, have you had any issues?

ALL THIS INFORMATION IS STRICTLY CONFIDENTIAL

Do you consent to having aesthetic treatments performed today? ___Yes ___No

Signature: Date: