Felina Brown, APRN, AG-ACNP
479.799.9978
felina.belle@gmail.com
IG: felinasaesthetics

Melissa Reidy, RN, BSN
402.517.2591
mreidy15@gmail.com
aestheticswithmelissa.com

PATIENT MEDICAL HISTORY

Name:_____ Date of Birth:_____ Age:_____ Sex: ☐ Female ☐ Male

Address:_____ City:_____ State:_____ Zip: _____

Phone:_____ Work Phone:_____ Email:_____

Please check if you are affected by, or have any of the following:

- ☐ Asthma
- ☐ Auto-Immune Disease
- ☐ Bell's Palsy
- ☐ Blood/Clotting Disorders
- ☐ Cardiac Issues/Pacemaker
- ☐ Depression/Anxiety
- ☐ Vision Issues or numbness
- ☐ Epilepsy
- ☐ Amyotrophic Lateral Sclerosis
- ☐ Headaches (chronic)
- ☐ Hepatitis
- ☐ Herpes, Fever Blisters/Cold Sores
- ☐ High Blood Pressure
- ☐ HIV/AIDS
- ☐ Hormonal Imbalance
- ☐ Lambert-Eaton Syndrome
- ☐ Myasthenia Gravis
- ☐ Pins/Plates/Metal Bone
- ☐ Neurological Issues
- ☐ Parkinson's
- ☐ Skin Disease
- ☐ Thyroid Issues
- ☐ Urinary/Kidney Issues
- ☐ Other:_____

Please list all medications you are currently taking (including herbal, over the counter, topical, oral, and supplemental):

_____

_____

Are you currently: ☐ Pregnant ☐ Trying to get pregnant ☐ Breastfeeding ☐ Lactating ☐ Taking Antibiotics ☐ Taking Birth Control ☐ Taking Hormone Replacements

Do you have any allergies to foods or medications? ☐ Yes ☐ No **Allergies:** _____

Do you have allergies/sensitivities to:

- ☐ Alcohol-Based Products
- ☐ Aloe Vera
- ☐ Aspirin
- ☐ Bee/Wasp Stings
- ☐ Bleaching Agents
- ☐ Bovine/Ovine
- ☐ Eggs
- ☐ Hydrocortisone
- ☐ Hydroquinone
- ☐ Latex
- ☐ Lidocaine
- ☐ Perfumes

Do you consider your skin to be/have: *Check all that apply*

- ☐ Normal
- ☐ Dry
- ☐ Oily
- ☐ Blotchy
- ☐ Sensitive
- ☐ Blackheads
- ☐ Acne
- ☐ Rosacea
- ☐ Eczema
- ☐ Melasma
- ☐ Psoriasis
- ☐ Rosacea
- ☐ Patchy Dryness
- ☐ Dehydrated
- ☐ Dark Circles
- ☐ Capillaries
- ☐ Hypopigment
- ☐ Hyperpigment
- ☐ Cysts
- ☐ Acne Scars
- ☐ Breakouts
- ☐ Milia
- ☐ Large Pores
- ☐ Small Pores

Have you/Do You:

Had Collagen, Botox, or other Dermal Filler Injections in the past? ☐ Yes ☐ No ***If Yes:*** *Treatment Date:*_____ *Product Name:*_____

Ever used Accutane? ☐ Yes ☐ No **Eyelid Droop or heavy when fatigued?** ☐ Yes ☐ No **Have Permanent Makeup?** ☐ Yes ☐ No

Ever had skin cancer? ☐ Yes ☐ No **Use tanning beds?** ☐ Yes ☐ No **Ever had eyelid or brow droop after Botox?** ☐ Yes ☐ No

Ever had facial surgery or suffered facial trauma? ☐ Yes ☐ No

*If yes, list date & type of surgery/trauma:*_____

Recently had laser resurfacing? ☐ Yes ☐ No *If yes, list date & type of treatment:*_____

Currently under physician's care for any skin problems? ☐ Yes ☐ No *Condition:* _____

In the last 10 days, have you taken: ☐ Aspirin ☐ Ibuprofen ☐ Fish Oil ☐ Blood Thinners ☐ Alcohol ☐ Vitamin E ☐ Steroids

I affirm the above information is accurate to the best of my knowledge and authorize the clinic staff to perform requested services. Clinic Staff are not responsible for any errors that may occur as a result of any omissions or incorrect information on this form.

Patient Name (Print) _____ **Patient Signature** _____ **Date** _____