Patient Information

- Full Name: _____
- Date of Birth: _____
- Address: _____
- Phone Number: _____
- Email: _____
- Emergency Contact (Name & Phone): _____

Medical History

- Primary Care Physician: _____
- Current Medications: _____
- Allergies (medications, foods, latex, etc.): _____
- Past Surgeries: _____
- Medical Conditions (check all that apply):
- ☐ Heart Disease
- ☐ High Blood Pressure
- ☐ Diabetes
- ☐ Neurological Disorders
- ☐ Autoimmune Disorders
- ☐ Bleeding Disorders
- ☐ Skin Conditions (e.g., eczema, psoriasis)
- ☐ Other: _____

Aesthetic Treatment History

- Have you had Botox or fillers before? ☐ Yes ☐ No
    - If yes, when and where? _____
- Have you had microneedling or dermaplaning before? ☐ Yes ☐ No
- Any adverse reactions to previous treatments? ☐ Yes ☐ No
- If yes, please describe: _____

Lifestyle Factors

- Do you smoke? ☐ Yes ☐ No
- Do you consume alcohol? ☐ Yes ☐ No
- Are you pregnant or breastfeeding? ☐ Yes ☐ No
- Do you have upcoming special events (weddings, photos, etc.)? ☐ Yes ☐ No

Treatment Goals

- What areas are you interested in treating?
- ☐ Forehead lines
- ☐ Crow's feet
- ☐ Frown lines
- ☐ Lip enhancement
- ☐ Skin texture improvement (microneedling/dermaplaning)
- ☐ Other: _____

Consent & Acknowledgment

I understand that Botox, fillers, microneedling, and dermaplaning are elective procedures. I have disclosed my full medical history and understand the risks, benefits, and alternatives. I consent to treatment and authorize the provider to perform the procedures discussed.

- Patient Signature: _____ Date: _____
- Provider Signature: _____ Date: _____