DERMAVIS COSMETIC *clinic*

Medical History

Name:_____ DOB: _____ Age:_____
Telephone:_____ Email: _____
Address:_____ Instagram:_____

MEDICAL HISTORY

Please list medications: (including prescription, oral, over the counter, topical, supplement or herbal)

_____

_____

Are you pregnant or lactating? (circle) Yes OR NO

Are you on any antibiotics? _____

Do you have any of the following medical conditions? (Please mark YES or NO to all)

PLEASE CHECK ALL THAT APPLY	YES	NO		YES	NO
Cancer			Diabetes		
High Blood Pressure			Herpes		
Arthritis			Frequent cold sores		
HIV/AIDS			Keloid scarring		
Skin Disease			Skin Lesions		
Seizure Disorder			Hepatitis		
Hormone Imbalance			Thyroid Imbalance		
Blood Clotting Abnormalities.			Any active infection		
Heart Conditions.			NEUROLOGICAL DISEASES:		
Parkinson's.			Myasthenia Graves		
Multiple Sclerosis (MS).			Lambert-Eaton Syndrome		
Amyotrophic Lateral Sclerosis (ALS)					