



DERMATOLOGY BY SHELLY

Cosmetic Medical History Form

Patient Information

Last Name: _____ First Name: _____ Phone: _____

DOB: ____ / ____ / ____ Female ____ Male ____

Address: _____

City: _____ State: _____ Zip Code: _____

Family Doctor: _____ Phone: _____

Pharmacy: _____ Phone: _____

Emergency Contact: _____ Phone: _____

Treatment Goals

Which body area(s) or condition(s) would you like treated?

3. Are you currently under a doctor's care?

Yes No

If yes, for what reason:

Medical History

1. Do you have ANY current or chronic medical illnesses? Yes No

(Including heat urticaria, diabetes, autoimmune or blood disorders, cancer, infections, or conditions affecting healing or photosensitivity.)

Please list:

4. Do you take/use ANY medications (prescription or over-the-counter), vitamins, herbal supplements, or natural supplements on a regular or daily basis?

Yes No

(Important: Some medications may cause contraindications with injectables or lead to blistering/burning with lasers.)

Please list:

2. Do you have a history of vitiligo, eczema, melasma, psoriasis, allergic dermatitis, Ehlers-Danlos syndrome, scleroderma, skin cancer, or other skin conditions? Yes No

Please list:

5. Have you ever had Gold Therapy Treatment (chrysotherapy, aurotherapy, gold sodium thiomalate)? Yes No

6. Do you use any topical products (medical, non-medical, OTC) on your skin regularly?

Yes No

Please list:

7. Do you use systemic/oral steroids such as prednisone or dexamethasone? Yes No

8. Do you have allergies to medications, food, latex, or other substances? Yes No

Please list:

9. History of herpes (cold sores) in the treatment area? Yes No

10. History of keloid or hypertrophic scarring? Yes No

11. History of light-induced seizures? Yes No

12. Do you have any open sores or lesions? Yes No

13. History of radiation therapy in the treatment area? Yes No

14. In the last 6 months, have you used anticoagulants, anti-inflammatories, or photosensitizing medications? Yes No

If yes, list product name and last date used:

15. In the last 3 months, have you used glycolic acid, AHAs/BHAs, exfoliating or resurfacing products/treatments? Yes No

Please list:

Cosmetic & Surgical History

16. Do you have or have you ever had permanent makeup, tattoos, implants, or fillers (collagen, autologous fat, Restylane®, Juvederm®, etc.)?

Yes No

Locations and dates:

17. Do you have or have you ever had Botox®, Dysport®, or other neurotoxins? Yes No

Locations and dates:

18. Have you taken Accutane® (isotretinoin) in the last 12 months? Yes No

Last dose:

19. Have you used Tretinoin (Retin-A, Renova, etc.) in the last 6 months? Yes No

20. Have you had unprotected sun exposure, tanning creams, self-tanners, tanning beds/lamps in the last 4–6 weeks? Yes No

21. Have you ever had a facelift, PDO threads, or facial reconstructive surgery? Yes No

(Important: Past facial procedures may alter musculature and vascular anatomy, impacting injectable and laser safety.)

Please list surgeries and dates:

Women's Health

- 22. Are you or could you be pregnant? Yes No
- 23. Are your menstrual periods regular? Yes No N/A
- 24. History of Polycystic Ovarian Syndrome (PCOS)? Yes No

Standard Disclaimers

- I acknowledge that cosmetic treatments carry risks including bruising, swelling, infection, scarring, pigment changes, or treatment failure.
- I understand that full disclosure of my medical history is essential for my safety.
- I understand that photos may be taken for medical documentation and treatment planning.
- I understand that results vary and cosmetic procedures are elective and non-refundable.
- I agree to notify the office if my medications or medical history change at any time.

Signature

Signature: _____ Date: _____

Print Name: _____