Cosmetic Medical History Form

Patient Information

First Name: _____ Last Name: _____(Circle) Male/Female/Non-binary

Phone: _____ Email: _____ DOB: ____ / ____ / _____

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?

_____ _____ _____

_____ _____ _____

_____ _____ _____

What do you feel is your *best* feature: _____

What do you feel is your *worst* feature: _____

Do you have fears when it comes to cosmetic treatments:_____

Do you have any upcoming trips planned □ **Yes** □ **No** _____

Do you have any traveling plans that include flying on an airplane? □ **Yes** □ **No**

When? _____

Medical History

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

Please list:

_____

_____

2. Are you currently under a doctor's care? □ **Yes** □ **No**

If yes, for what reason:

_____

4. Please check if you have any of the following currently or history of:

Vitiligo □ **Yes** □ **No**

Eczema □ **Yes** □ **No**

Melasma □ **Yes** □ **No**

Psoriasis □ **Yes** □ **No**

Atopic (allergic) dermatitis □ **Yes** □ **No**

History of or Current Skin cancer □ **Yes** □ **No**

Organ Transplant □ **Yes** □ **No**

Scleroderma □ **Yes** □ **No**

Ehlers-Danlos syndrome □ **Yes** □ **No**

Continued on the next page…….

Autoimmune Conditions □ **Yes** □ **No**
Immunosuppression □ **Yes** □ **No**
(Compromised Immune System)
Pigmentation disorders □ **Yes** □ **No**
Coagulation Disorders □ **Yes** □ **No**
Blood -Thinning Medications □ **Yes** □ **No**
Bacterial or Viral Infection □ **Yes** □ **No**

Cardiovascular Disease □ **Yes** □ **No**
Neuromuscular Disorder □ **Yes** □ **No**
Dysphagia (Trouble Swallowing) □ **Yes** □ **No**
Breathing Difficulties □ **Yes** □ **No**

Please Explain ANY YES's marked above:_____
_____
_____

5. 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.Kindly take the time to do this as this is extremely important for us to give you the best care possible)* Please list:

_____ _____ _____
_____ _____ _____
_____ _____ _____
_____ _____ _____
_____ _____ _____
_____ _____ _____

6. Have you ever had Gold Therapy Treatment (chrysotherapy, gold sodium thiomalate)? (These are sometimes still used for rheumatic Dz/autoimmune diseases) □ **Yes** □ **No**

7. Do you use systemic (oral) steroids such as prednisone or dexamethasone? □ **Yes** □ **No**

8. What products do you use on your skin regularly (medical, non-medical, OTC)
Please list:

_____ _____ _____
_____ _____ _____
_____ _____ _____

9. Do you use systemic/oral steroids such as prednisone or dexamethasone? □ Yes □ No
If yes, what is it for: _____

10. What vaccinations have you had in the last year? _____
11. Do you plan on getting any vaccinations in the next 6 months? _____
12. Have you had any dental procedures or cleanings in the last month? □ **Yes** (when_____) □ **No**
13. Do you have any planned dental procedures or cleanings in the next month? □ **Yes** □ **No**
14. Do you have any upcoming medical procedures planned? □ **Yes** (explain)_____ □ **No**
15. Do you have any upcoming or recent tattoos? □ **Yes** □ **No**
16. Do you have any upcoming social events/vacations (when)_____

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

Allergy Item:	**Reaction:**
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

18. History of herpes (cold sores) in the treatment area? □ **Yes** □ **No**
19. History of keloid or hypertrophic scarring? □ **Yes** □ **No**
20. History of light-induced seizures? □ **Yes** □ **No**
21. Do you have any open sores or lesions? □ **Yes** □ **No**
22. History radiation therapy in desired treatment areas? □ **Yes** □ **No**
23. In the last 6 months, have you used anticoagulants, anti-inflammatories, antibiotics or photosensitizing medications? □ **Yes** □ **No**

MEDICATION	LAST USED
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Cosmetic & Surgical History

1. In the last 3 months, have you used glycolic acid, AHAs/BHAs, exfoliating or resurfacing products or had any type of lasers or microneedling/microchanneling or other facial treatments? □ **Yes** □ **No**
Please list: _____

2. Do you have or have you ever had permanent makeup, tattoos, implants, or fillers (collagen, autologous fat, Restylane®, Juvederm®, etc.)? □ **Yes** □ **No**
Location/When: _____

3. Do you have or have you ever had Botox®, Dysport®, or other neurotoxins? □ **Yes** □ **No**
Locations/last received: _____
4. Have you taken Accutane® (isotretinoin) in the last 12 months? □ **Yes** □ **No**
Last dose:_____

5. Have you used Tretinoin (Retin-A, Renova, etc.) or other retinoids in the last 6 months? □ **Yes** □ **No**
Last Used: _____

6. Have you had unprotected sun exposure, tanning creams, self-tanners, tanning beds/lamps in the last 4–6 weeks? □ **Yes** (which one): _____ □ **No**

7. 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 answer honestly for your own safety during injections*)
Please list surgeries and dates:

_____ _____ _____
_____ _____ _____

8. Have you ever had any facial trauma? □ **Yes** □ **No**
Please explain:_____
_____

Women's Health

1. Are you or could you be pregnant? □ **Yes** □ **No**
2. Are your menstrual periods regular? □ **Yes** □ **No** □ **N/A**
3. History of Polycystic Ovarian Syndrome (PCOS)? □ **Yes** □ **No**
4. Are you □ pre □ post, or □ perimenopausal? □ **N/A**

Standard Disclaimers

I acknowledge that cosmetic treatments carry risks including allergic reactions, lumps, bumps, bruising, swelling, infection, scarring, pigment changes, vascular occlusion and subsequent necrosis, blindness, dissatisfaction or treatment failure. (Initials) _____
I understand that full disclosure of my medical history is essential for my safety. (Initials)_____
I understand that full disclosure of ALL of my medications is essential for my safety. (Initials)_____
I understand that photos may be taken for medical documentation and treatment planning. (Initials)_____
I understand that results vary and cosmetic procedures are elective and non-refundable. (Initials)_____
I agree to notify the office if my medications or medical history change at any time. (Initials)_____

Signature: _____ **Date:** _____

Print Name: _____

Reviewed By: _____ **Title:** _____ **Date:** _____/_____/_____

We appreciate you, your support, kindness, understanding and patience with our medical paperwork.

~ Shelly ~