RX Refresh Face and Body/ Fresh Faces US

Patient History

Last Name:_____First: _____ Nickname:_____ Date:_____

Address: _____City: _____ State: _____ Zip:_____

Email:_____ Occupation:_____

Birthday:___/___/_____ Age:_____ Cell Phone:_____ Sex:_____

Medical Provider: _____ Emergency Contact/ Phone:_____

May we contact you for reminders Y/ N / special offers Y / N? Best Method:_____

My biggest concern for coming here: _____

Medications: _____

ALLERGIES: _____

Are you allergic to: Aspirin Y/N Lidocaine Y/N Adhesives Y/N ? Other:

Medical Conditions: _____

Neurological Disorders: Y/ N Explain: _____

Diabetes: Y/N ____ Have you had or tested positive for Covid-19? _____Temperature _____

Do you smoke Y/N, vape Y/N, use tobacco products Y/N ?

Have you ever had oral outbreaks of herpes simplex around your mouth / lips Y/ N?

Past Surgical Procedures: _____

Cosmetic Procedures: _____

Have you ever received: Botox Y/N Last date_____ Results_____
Xeomin Y/N Last date_____ Results _____
Dysport Y/N Last date_____ Results_____
Jeuveau Y/N Last date_____ Results_____

Have you ever received Fillers Y/N? Types_____

When _____ Results_____

Have you ever had a chemical peel Y/N, Microneedling Y/N , Laser Therapy Y/N ?

I have provided accurate information for the above questions to the best of my knowledge.

Patient signature:_____ Date:_____