Glow Health
MEDICAL CLINIC

Aesthetic Medical History Form

Name:	Date:
Address:	City:
State/Zip:	Email Address:
Date of Birth: Age: _____	Phone Number:
Occupation:	Allergies:
Emergency Contact:	Relationship to you:
Emergency Contact Phone Number:	

HISTORY

Please check if you have or have had –

Allergy to Eggs or Albumin	Amyotrophic Lateral Sclerosis (ALS)
Diabetes	Hepatitis
Eaton-Lambert Syndrome	Myasthenia Gravis
Cancer (please explain)	Allergy to Lidocaine
Herpes	Menopause
Hysterectomy	Hypertension
Irregular menses	Heart Problems
Photosensitive Disorder	Autoimmune Illness
Sensitive to Anesthetic	Lupus
Bleeding Disorder	Current use of Aspirin and/or NSAIDs such as Ibuprofen, Aleve, Advil

Medical Illness(s)_____

Past Surgeries: _____

Current/Recent medications _____

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			IF YES, EXPLAIN
Keloid scars	no	yes	_____
Hives	no	yes	_____
Skin Cancer	no	yes	_____
Waxing	no	yes	_____
Electrolysis	no	yes	_____
Cold Sores	no	yes	_____
Hypersensitivity to skin products	no	yes	_____
Skin Infections	no	yes	_____
Tanning within the last 6 wks	no	yes	_____
Use of acne products/drugs	no	yes	_____
Laser skin resurfacing	no	yes	_____
Chemical Peels	no	yes	_____
Photosensitizing substances (Retin-A)	no	yes	_____
Laser work of any type	no	yes	_____
Currently Pregnant	no	yes	_____
Currently Breastfeeding	no	yes	_____

Requested Treatment:

BOTOX Frown lines (between the eyes) Horizontal forehead lines Crow's Feet Lip Lines/Lip Flip Other: _____	**CRYO THERAPY** Fat Reduction Body Sculpting Cellulite Treatment Cryo Face Treatment Acne Treatment
HA FILLER Cheeks/midface Perioral/around mouth Chin Lips	**SKINVIVE** Skin hydration for face Skin hydration for neck
MICRONEEDLING with or /without **Exosomes** Face, Neck and/or Chest Hair Regeneration Hands	**BIOREPEEL "The no peel, peel"!** Overall Skin Rejuvenation/Glow/Skin Tone Reduce appearance of Acne/Acne Scars Reduce/improve pigmentation/laxity Reduce/improve fine lines/wrinkles

I ATTEST THE ABOVE INFORMATION TO BE TRUE, KNOWING MY PROVIDER RELIES ON THIS INFORMATION TO PROVIDE SAFE AND EFFECTIVE TREATMENT.

Patient Signature_____Date _____