

Aesthetic Medical History Form

Name:	Date:
Address:	City:
State/Zip:	Email Address:
Date of Birth:	Age _____ Sex _____
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
Excessive Scarring/Keloid	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

Are you under the care of a physician?if yes, please provide name/phone number

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	no	yes _____
Laser work of any type	no	yes _____
Currently Pregnant	no	yes _____
Currently Breastfeeding	no	yes _____

Medical Illness(s) _____

Allergies of any kind including meds: _____

Requested Area(s) of Treatment:

<p>BOTOX Frown lines (between the eyes) Horizontal forehead lines Crow's Feet Lip Lines/Lip Flip</p>	<p>FILLER - Restylane Kysse Lip Augmentation</p>
<p>MICRONEEDLING Face, Neck and/or Chest Scalp Hands</p>	<p>MICRONEEDLING with Exosomes Face, Neck and/or Chest Scalp Hands</p>

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

Patient Signature _____ Date _____