Glow Health
MEDICAL CLINIC

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:

BOTOX Frown lines (between the eyes) Horizontal forehead lines Crow's Feet Lip Lines/Lip Flip Other: _______________	**CRYO THERAPY** Body Sculpting Cellulite Treatment Cryo Facial
MICRONEEDLING Face, Neck and/or Chest Scalp Hands	**MICRONEEDLING with Exosomes** Face, Neck and/or Chest Scalp Hands

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

Patient Signature____Date _____________