# Medical & Personal History

Name: _____ Date: _____

Birth Date (mm/dd/yyyy): _____/_____/_____ Age:_____

How did you hear about us?_____

Address:_____ Apt#_____

City: _____State:_____ Zip: _____

Phone: (Cell) _____(Home) _____ (Work)_____

Prefered method of contact: ◯ PHONE ◯ TEXT ◯ EMAIL

Occupation:_____ Email Address: _____

Emergency Contact: _____ Phone: _____

**MEDICATIONS:** Prescription and non-prescription medicines, vitamins, home remedies, birth control pills, herbs, etc.

| Medication | Dose (e.g., mg/pill) | Reasons For Each |
|---|---|---|
| | | |
| | | |

**ALLERGIES:** Allergies or reactions to medications, creams and/or foods:

_____

**SURGERIES:**

_____

**PERSONAL MEDICAL HISTORY:** Please indicate whether you currently have or have had any of the following medical conditions (with dates)

| | | |
|---|---|---|
| ☐ Acne | ☐ Recent Fever/Cold/Flu | ☐ Lipomas (Fatty Tumors) |
| ☐ Auto-Immune Disease | ☐ Gastrointestinal | ☐ Neurological |
| ☐ Cardiac Disease | ☐ Hypertension | ☐ Organ Transplant |
| ☐ Cancer | ☐ HIV/AIDS | ☐ Psychiatric |
| ☐ Diabetes | ☐ Kidney Disorders | ☐ Recent Weight Gain/Loss |
| ☐ Eating Disorder | ☐ Liver Disorders | ☐ Skin Conditions |
| ☐ Epilepsy/Seizure Disorders | ☐ Lymphatic Disorders | ☐ **COVID-19** |

*Explain:*_____

Do you have any metal implants? (including Mouth/ Jaw area) YES / NO

If yes, please explain where: _____

Do you have any electrical support systems in your body (i.e. pacemakers, automatic defibrillator, cardioverter)? YES / NO

Do you have any other type of implantable devices? YES / NO

Are you currently pregnant or trying to get pregnant? YES / NO

Are you Breastfeeding? YES / NO

Are you currently on a method of birth control? YES / NO

Type Used:_____

Are you post menopausal? YES / NO

Have you had a Hysterectomy? YES / NO

Have you had your COVID-19 Vaccine? YES / NO

## COSMETIC HISTORY & SKIN ASSESSMENT:

Ethnicity: □ Caucasian □ Hispanic □ African American □ Asian □ Indian □ Native American

□ Other:_____

Have you had any complications as a result of any cosmetic procedure? YES / NO

If yes, please explain:_____

Have you recently had any Botox or soft tissue fillers? YES / NO
(i.e. Restylane, Juvederm)

Have you ever used Accutane, Retin A, Renova, Differin, Tretinoin Hydroquinone, Tazorac or any other prescription skin products? YES / NO

Is there any other information that you feel may be related to or is pertinent to your treatment?

If so, please explain.

_____

_____

**Patient Signature:** _____ **Date:** _____