Patient Information & Medical History Form: CONFIDENTIAL

Your health is important to us. Please fill this out as accurately and completely as possible. Please take care to print legibly. Please note your preferred method of contact by checking the box for email, mobile phone, or home phone.

PERSONAL INFORMATION:			
First	Middle	Last	Date:
Address:		Email: PREFFERED ❑	
City, State, Zip:		Mobile Phone: PREFFERED ❑	
Birthdate:	Gender: M ❑ F ❑	Home Phone: PREFFERED ❑	

TREATMENT CHECK-IN:

Are you currently under the care of a Health Care Provider? (If yes, please explain):

What was your most recent cosmetic treatment? (If this is your first cosmetic treatment, please state so.)

Person/Company who provided the treatment(s)?	Date of Last Treatment:

Have you ever fainted during or immediately following an aesthetic procedure? YES ❑ NO ❑	Have you ever had a cosmetic procedure you did not like the outcome of? YES ❑ NO ❑
Have you ever had a Rhinoplasty? YES ❑ NO ❑ (If yes, how many? : _____) If so, did you experience any pain? YES ❑ NO ❑	Are you allergic to Eggs? YES ❑ NO ❑ Are you allergic to Milk Protein? YES ❑ NO ❑ Are you allergic to Lidocaine®? YES ❑ NO ❑

Do you have any other allergies or can you think of something you've had an adverse reaction to? ❑ I do not have any known allergies (or) ❑ I have an allergy or adverse reaction to (Please list):

CURRENT MEDICATIONS:

List any medications that you are now taking below. Please include any & all non-prescription (over-the-counter) medications, vitamins, & supplements.

NAME (Medication/Vitamin/Supplement)	DOSE (Please Include Strength/Per Day)	LENGTH (How long have you been taking this?)
1.		
2.		
3.		
4.		

REPRODUCTIVE HISTORY (Men, please skip to the next section):

Are you currently pregnant? YES ❑ NO ❑	Have you been pregnant within the last year? YES ❑ NO ❑	Are you currently breastfeeding? YES ❑ NO ❑

SKIN HISTORY – Do you have or have you ever had:

	Please circle one:		If yes, please explain (Provide frequency & most recent occurrence):
Keloid Scars	YES	NO	
Hives	YES	NO	
Skin Cancer	YES	NO	
Waxing	YES	NO	
Electrolysis	YES	NO	
Cold Sores	YES	NO	
Hypersensitivity to Skin Products	YES	NO	
Skin Infections	YES	NO	
Tanning Within the Last 6 Weeks	YES	NO	
Use of Acne Products or Drugs	YES	NO	
Laser Skin Resurfacing	YES	NO	
Chemical Peels	YES	NO	
Photo-sensitizing substances:	YES	NO	

Antibiotics, Diuretics, & Blood Pressure Medicine are all examples of photosensitizing substances.

Additional Information you would like to share related to your health (if any):

AGREED & SIGNED:

I attest the above information to be true, knowing my practitioner(s) rely on this information to provide the most safe and effective treatment.
Print Name:

Patient Signature:	**Date:**