

# COSMETIC MEDICAL HISTORY FORM

Name: \_\_\_\_\_

Phone: \_\_\_\_\_

Allergies: \_\_\_\_\_

Medications (including vitamins, supplements): \_\_\_\_\_

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## PLEASE ANSWER THE FOLLOWING QUESTIONS:

1. Have you ever had or been treated for any of the following? (Check all that apply)

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Artificial heart valves | <input type="checkbox"/> Difficult wound healing | <input type="checkbox"/> Kidney disease        |
| <input type="checkbox"/> Artificial joints       | <input type="checkbox"/> Easy bruising/bleeding  | <input type="checkbox"/> Liver disease         |
| <input type="checkbox"/> Asthma                  | <input type="checkbox"/> Eczema                  | <input type="checkbox"/> Neuromuscular disease |
| <input type="checkbox"/> Autoimmune disease      | <input type="checkbox"/> Fever blisters          | <input type="checkbox"/> Seizures              |
| <input type="checkbox"/> Cancer                  | <input type="checkbox"/> Glaucoma                | <input type="checkbox"/> Skin cancer           |
| <input type="checkbox"/> Cold sores              | <input type="checkbox"/> Heart disease           | <input type="checkbox"/> TB or Lung disease    |
| <input type="checkbox"/> Blood clots/Phlebitis   | <input type="checkbox"/> High blood pressure     | <input type="checkbox"/> Thyroid disease       |
| <input type="checkbox"/> Depression              | <input type="checkbox"/> Hives                   | <input type="checkbox"/> Ulcers                |
| <input type="checkbox"/> Diabetes                | <input type="checkbox"/> Keloids/Overgrown scars | <input type="checkbox"/> Other                 |

Yes      No

- |  |                          |                          |
|--|--------------------------|--------------------------|
| 2. Are you or could you be pregnant?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Do you have a history of Herpes I or II in the area to be treated?                                    | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Do you have a history of keloid scarring?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Have you taken Accutane in the last 6 months?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Are you currently taking retinoids (Retin-A, Renova)?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Do you have any permanent make-up, implants or tattoos?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Have you had any unprotected sun exposure, used tanning creams or tanning beds in the last 4-6 weeks? | <input type="checkbox"/> | <input type="checkbox"/> |

## PLEASE INDICATE THE SERVICES THAT INTEREST YOU (CHECK ALL THAT APPLY):

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Acne Treatment        | <input type="checkbox"/> Laser hair reduction    | <input type="checkbox"/> Scars and Wrinkles |
| <input type="checkbox"/> Blood vessels/Rosacea | <input type="checkbox"/> Laser Resurfacing       | <input type="checkbox"/> Skin care products |
| <input type="checkbox"/> Botox                 | <input type="checkbox"/> Leg Veins/Sclerotherapy | <input type="checkbox"/> Skin rejuvenation  |
| <input type="checkbox"/> Collagen/Fillers      | <input type="checkbox"/> Pigment/Sunspots        | <input type="checkbox"/> Skin tightening    |

Signature \_\_\_\_\_

Date \_\_\_\_\_