

# Medical History Form

PLEASE ANSWER EVERY QUESTION

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Date: \_\_\_\_\_

Reason for your visit?

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Fat Reduction (Lipo)   | <input type="checkbox"/> HCG Weightloss Program                                 | <input type="checkbox"/> Laser Hair Removal |
| <input type="checkbox"/> Cellulite Reduction (SmoothShapes Laser)   | <input type="checkbox"/> Botox Cosmetic, Dysport                                | <input type="checkbox"/> Vein Removal       |
| <input type="checkbox"/> Skin Tightening Aluma  | <input type="checkbox"/> Facial Filler (Perlane, Restylane, etc)                | <input type="checkbox"/> Rosacea            |
| <input type="checkbox"/> Acne or Acne Scars   | <input type="checkbox"/> Chemical Peels   | <input type="checkbox"/> Dermabrasion       |
| <input type="checkbox"/> Facial Vitamin Therapy Vitalift  | <input type="checkbox"/> Lip Augmentation                                       | <input type="checkbox"/> Skin Tag Removal   |
| <input type="checkbox"/> Laser Rejuvenation (CO2 Laser)   | <input type="checkbox"/> IPL (sun spots, age spots, hyperpigmentation, melasma) |   |
| <input type="checkbox"/> Plastic Surgery: (Breast augmentation, Tummy Tuck, Eyelid surgery, Nose surgery, Facelift, Brow lift, Breast Lift) |   |   |
| <input type="checkbox"/> Other _____  |   |   |

Have you ever been treated for this problem? \_\_\_\_\_

How are you currently treating this problem? \_\_\_\_\_

- |  |  |
|--|--|
| Do you have any allergies? (Include any drug allergies)    | <input type="checkbox"/> No <input type="checkbox"/> Yes: _____  |
| Do you smoke?  | <input type="checkbox"/> No <input type="checkbox"/> Yes: _____  |
| Do you use drugs?  | <input type="checkbox"/> No <input type="checkbox"/> Yes: _____  |
| Do you have Diabetes?                                      | <input type="checkbox"/> No <input type="checkbox"/> Yes...if yes, are you insulin dependent? <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Do you experience Herpes breakouts?                        | <input type="checkbox"/> No <input type="checkbox"/> Yes: _____  |
| Are you subject to abnormal photosensitivity?              | <input type="checkbox"/> No <input type="checkbox"/> Yes: _____  |
| Are you subject to excessive scarring (keloid formation)?  | <input type="checkbox"/> No <input type="checkbox"/> Yes: _____  |
| Do you have any tattoos or permanent makeup?               | <input type="checkbox"/> No <input type="checkbox"/> Yes: _____  |
| Any history of cancer or chemotherapy?                     | <input type="checkbox"/> No <input type="checkbox"/> Yes: _____  |
| Any bleeding disorders?                                    | <input type="checkbox"/> No <input type="checkbox"/> Yes: _____  |
| Any inflammatory skin conditions?                          | <input type="checkbox"/> No <input type="checkbox"/> Yes: _____  |
| Any surgeries?   | <input type="checkbox"/> No <input type="checkbox"/> Yes: _____  |
| Any heart problems?  | <input type="checkbox"/> No <input type="checkbox"/> Yes: _____  |
| Do you have a pacemaker?                                   | <input type="checkbox"/> No <input type="checkbox"/> Yes: _____  |
| History of stroke?   | <input type="checkbox"/> No <input type="checkbox"/> Yes: _____  |
| History of blood clots?                                    | <input type="checkbox"/> No <input type="checkbox"/> Yes: _____  |
| History of thyroid disorder?                               | <input type="checkbox"/> No <input type="checkbox"/> Yes: _____  |
| Any immune deficiency problems?                            | <input type="checkbox"/> No <input type="checkbox"/> Yes: _____  |
| History of Vitiligo or Porphyria?                          | <input type="checkbox"/> No <input type="checkbox"/> Yes: _____  |
| Lupus, Rheumatoid Arthritis, or Scleroderma?               | <input type="checkbox"/> No <input type="checkbox"/> Yes: _____  |
| Dizziness, fainting, nervous disorders, heart palpitation? | <input type="checkbox"/> No <input type="checkbox"/> Yes: _____  |
| History of hyper or hypo-pigmentation?                     | <input type="checkbox"/> No <input type="checkbox"/> Yes: _____  |
| Any other active skin or general diseases?                 | <input type="checkbox"/> No <input type="checkbox"/> Yes: _____  |
| Are you currently pregnant or planning to get pregnant?    | <input type="checkbox"/> No <input type="checkbox"/> Yes: _____  |
| Are you breast feeding?                                    | <input type="checkbox"/> No <input type="checkbox"/> Yes: _____  |

Have you ever used Accutane, Retin A, Glycolic Acid, Alpha Hydroxy, Topical Cortisone?  No  Yes...If Yes, list when and how often? \_\_\_\_\_

What medications are you taking (including aspirin)? \_\_\_\_\_

How often do you consume alcohol? \_\_\_\_\_

When were you last exposed to prolonged sun exposure, used a tanning booth, or used self-tanner? \_\_\_\_\_

*I acknowledge that I have received a copy of my HIPPA Rights and Responsibilities.*

**Signature of patient**