Client Information & Medical History

Client Name: ______________________________ Date of Birth: ____________________

Address: ______________________ City: ___________ State: _____ Zip Code: ________

Home: (____)_______-_________ Cell: (______)_______-_________ Email: ______________________

How did you hear about us? ____

Emergency Contact Person/Relation: ____________________________ Phone: (______)________-_________

What method of payment is best for you? ☐ Financing ☐ Cash ☐ Check ☐ Credit Card

Please indicate the services and areas of interest:

Yes	No	Service	Areas
☐	☐	Botox/Dysport Treatment	
☐	☐	KYBELLA Treatment	
☐	☐	Dermal Fillers	
☐	☐	Skincare/Rejuvenation	
☐	☐	Other (Please Specify)	

Have you ever had any of the above services before? Please List: ______________________________

Were there any complications? If yes, please specify: ______________________________

____

Do you have or have you ever had any of the following:

Yes	No	Medical History	If Yes, Please Specify
☐	☐	Permanent Make-up	
☐	☐	Tattoos	
☐	☐	Recent Cosmetic Procedures	Date Completed:
☐	☐	Botox/Restylane/Dermal Fillers	Date Completed:
☐	☐	Facial Skin Products	

Medication History

Yes	No	Medical History	If Yes, Please Specify
☐	☐	Current Medications	
☐	☐	Over-the-Counter Medications	
☐	☐	Herbal Supplements	
☐	☐	Retin-A or Generics	
☐	☐	Blood Thinner (Coumadin, Aspirin)	
☐	☐	Acne Medication	
☐	☐	Oral Contraceptives	
☐	☐	Accutane	Date Completed:
☐	☐	Antibiotics	Date Completed:
☐	☐	Food Allergies	
☐	☐	Medication Allergies	
☐	☐	Latex Allergies	

Do you have or have you ever had any of the following:

Yes	No	Medical History	If Yes, Please Specify
☐	☐	Seizures and/or Epilepsy	
☐	☐	Diabetes	
☐	☐	Numbness	
☐	☐	Autoimmune Disorders	
☐	☐	Sarcoidosis	
☐	☐	Lupus	
☐	☐	Scleroderma	
☐	☐	Skin Disorders	
☐	☐	Vitiligo	
☐	☐	Keloid/Hypertrophic Scarring	
☐	☐	Present Scarring	
☐	☐	Herpes Virus/Cold Sores	
☐	☐	Blog Clothes/Phlebitis/Bleeding Disorders	
☐	☐	Lymphedema	
☐	☐	Cancer and/or Pre-Cancerous Lesions	
☐	☐	Polycystic Ovarian Syndrome	
☐	☐	Pregnancy/Actively Trying to Get Pregnant	
☐	☐	Pacemakers/Internal Pacing Devices	
☐	☐	Internal Metal Devices (rods, plates, screws)	
☐	☐	Lymph Node Removal	
☐	☐	Past Surgeries	
☐	☐	HIV/AIDS	
☐	☐	Multiple Sclerosis	
☐	☐	Chemotherapy/Radiation Therapy	

I, ______________________________, understand the information on this form is essential to determine my medical and cosmetic needs and the provision of treatment. I understand that if any changes occur in my medical history/health I will report it to the office as soon as possible. I have read and understand the above medical history questionnaire. I acknowledge that all answers have been recorded truthfully and will not hold any staff member responsible for any errors or omissions that I have made in the completion of this form.

______________________________ ______________________________

Client Signature Date

Reviewed With:

______________________________ ______________________________

Practitioner Signature Date