MEDICAL HISTORY

Name _____ **Address** _____
City _____ **State** _____ **Zip** _____ **Email** _____
Home Phone _____ **Work/Cell Phone** _____
Primary Physician's Name _____ **Phone #** _____
DOB _____ **Age** _____ **Height** _____ **Weight** _____

Please list all medications/vitamins you are currently taking: _____
_____

Allergies: _____ **Are you on Antibiotics at this time?** _____

Do you have any of the following conditions? (Check Yes or No)

YES	NO		YES	NO	
☐	☐	Cold Sores, when? _____	☐	☐	Diabetes?
☐	☐	Active Cancer? _____	☐	☐	Use Tobacco Products?
☐	☐	Abnormal Heart Condition _____	☐	☐	Cosmetic Surgeries?
☐	☐	High/ Low Blood Pressure (Circle)	☐	☐	Facial Cosmetic Surgery?
☐	☐	Fainting/Dizzy Spells? _____	☐	☐	Pregnant, or Nursing?
☐	☐	Prolonged Bleeding, why? _____	☐	☐	Vaccine in last 30 days?

List and/or Explain Other Medical Conditions not listed above: _____

Have you had Plastic Surgery or other surgery to your face/neck areas? If so, when? _____
_____

Have you had any type of Laser, Botox, Dermal Fillers (Restylane, Radiesse, Sculptra, Juvederm), performed on your face or have scheduled in the future? If so, which procedure(s)? Where on your face? When performed or scheduled?

_____
_____

Were you pleased with your result(s)? Any complications/concerns? _____

How did you hear about us? _____

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.

Patient Signature _____ **Date** _____