# HEALTH HISTORY FORM

## Non-surgical Medical Aesthetics

Date: _______________

Name ____________________________________________ DOB _______________ Age _______

Gender: Male / Female / Other Marital status: Single / Married / Widowed / Divorced

Address _____________________________ City __________________ State ______ Zip__________

Home Phone: _________________________ | Emergency Contact:___________________________

Cell Phone: __________________________ | Contact's Phone: ____________________________

Work Phone:_________________________

Email ________________________________________________________________

Employer: _________________________ Occupation: ________________________________________

Pharmacy: ________________________________ Pharmacy Phone: _____________________________

**Medical History**

Have you ever been diagnosed or treated for any of the following conditions? □ No □ Yes
(Please check all that apply.)

| | | |
|---|---|---|
| □ Acne | □ Heart disease/ cardiac arrest | □ Myasthenia Gravis |
| □ Auto-immune disorder | □ Herpes Simplex/ cold sore | □ Neurological problem |
| □ Blood disorder - bleeding | □ High blood pressure | □ PCOS/ ovarian cysts |
| □ Blood disorder - clotting | □ Hirsutism | □ Psoriasis |
| □ Burns/ skin grafts | □ HIV | □ Psychiatric disorder |
| □ BPH (males) | □ Hormone imbalance | □ Scarring issue/ keloid scarring |
| □ Cancer | □ Hyperpigmentation | □ Stroke |
| □ Diabetes | □ Kidney disease | □ Thyroid disorder |
| □ Dizziness/ fainting | □ Muscle weakness | □ Vitiligo |

If you checked any of the above, please explain:

______________________________________________________________________________

______________________________________________________________________________

Are you currently pregnant, trying to conceive, or nursing? □ No □ Yes
Do you smoke? □ Never □ Occasionally □ Regularly □ Frequently
Do you drink alcohol? □ Never □ Occasionally □ Regularly □ Frequently
Sun Exposure history? □ Never □ Occasionally □ Regularly □ Frequently

**Allergies**

Do you have any allergies: □ No □ Yes If yes, please list all known allergies:

□ Medications:

______________________________________________________________Rection:__________________________

□ Food:

______________________________________________________________Reaction:__________________________

□ Latex:

______________________________________________________________Reaction:__________________________

□ Skin Sensitives:

______________________________________________________________Reaction:__________________________

Have you ever experienced anaphylaxis?

□ No □ Yes: ______________________________________________________________________________

**Medications**

Please list your current prescription medications: □ No □ Yes

______________________________________________________________________________________________

Please list your current over the counter (OTC) medications or vitamins and/or supplements::

______________________________________________________________________________________________

Please list your current topical medications:

______________________________________________________________________________________________

Please list your current cosmetic/dermatologic product usage:

______________________________________________________________________________________________

Have you received Accutane therapy in the last 12 months? □ No □ Yes

Have you ever been treated with a neurotoxin (Botox, Dysport, Xeomin)? □ No □ Yes, ______________________

Have you ever been treated with dermal filler (Juvederm, Restylane, etc)? □ No □ Yes, ______________________

**Surgery or Hospitalization**

□ Cosmetic (Please explain what and when.):

________________________________________________________________________________

________________________________________________________________________________

□ Therapeutic (Please explain what and when.):

________________________________________________________________________________

________________________________________________________________________________

□ Hospitalization (Please explain why and when.):

________________________________________________________________________________

________________________________________________________________________________

Primary Care Physician:

______________________________________________Address:_____________________________________

**Please sign below to indicate all the information on this form is accurate and complete to the best of your knowledge.**

______________________________________________ Date________________

Patient signature

______________________________________________

Print name

______________________________________________ Date________________

Witness signature