



**HEALTH HISTORY**

To ensure both the effectiveness and the safety of your treatment, please complete this health history as accurately as you can.

**PERSONAL INFORMATION**

Date: \_\_\_\_\_

Last Name: \_\_\_\_\_ First: \_\_\_\_\_ MLL: \_\_\_\_\_

Street Address: \_\_\_\_\_ City: \_\_\_\_\_

State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Cell: \_\_\_\_\_

***(please put in the phone number(s) we can notify you for cancelled or changed appointments)***

Email: \_\_\_\_\_

Date of Birth (month/day/year): \_\_\_\_\_ Age: \_\_\_\_\_ Sex: Female / Male

WHERE DID YOU HEAR ABOUT US: (Please be specific)

Magazine \_\_\_ Internet \_\_\_ Referral \_\_\_ Newspaper \_\_\_

Other: \_\_\_\_\_

I AM INTERESTED IN: (Please check all that apply)

BOTOX                       SKIN REJUVENATION/PHOTOREJUVENATION

SKIN CARE ADVICE / PRODUCTS                       SKIN TIGHTENING

FILLERS  MICRODERMABRASION                       PORTRAIT

ROSACEA  LIVER SPOTS / AGE SPOTS  FACIAL VEIN TREATMENTS

ACNE TREATMENTS  LASER LEG VEIN / SPIDER VEIN TREATMENTS

OTHER, PLEASE SPECIFY: \_\_\_\_\_

DO YOU USE SUNSCREEN?

YES, IF YES WHICH SPF # \_\_\_\_\_  NO

WHEN YOU SUNBATHE, HOW DOES YOUR SKIN RESPOND?

- ALWAYS BURN, NEVER TAN  USUALLY BURN, TAN WITH DIFFICULTY  
 ALMOST NEVER BURN, TAN VERY EASILY  RARELY BURN, TAN EASILY  
 SOMETIMES BURN, TAN ABOUT AVERAGE  NEVER BURN, ALWAYS TAN

MEDICAL HISTORY (Check appropriate box next to any condition for which you have ever been treated)

- ACNE  ARTHRITIS  AUTOIMMUNE DISORDER  BLOOD DISORDERS  
 CANCER (OR RADIATION THERAPY)  DIABETES / DIABETIC NEUROPAHGHY  HERPES (OR COLD SORES)  
 HIRSUTISM  VITILIGO  KIDNEY DISEASE  MELANOMA  PORT WINE STAIN  
 PSORIASIS  PACEMAKER  SHINGLES  SKIN PIGMENTATION  
 STEROID OR HORMONAL THERAPY  HORMONAL IMBALANCES  
 POLYCYSTIC OVARIUM SYNDROME  KELOID SCARS / OTHER Scars

ADDITIONAL QUESTIONS:

1. ARE YOU CURRENTLY BEING TREATED FOR ANY CONDITIONS NOT LISTED? IF YES, PLEASE SPECIFY.

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2. ARE YOU CURRENTLY TAKING ANY MEDICATIONS, INCLUDING HERBAL PREPARATIONS, MEDICAL PATCHES OR ASA? IF YES, PLEASE SPECIFY.

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3. DO YOU HAVE ANY ALLERGIES? IF YES, PLEASE SPECIFY.

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4. HAVE YOU EVER USED (OR ARE CURRENTLY USING) RETIN A OR GLYCOLIC ACID? IF YES, PLEASE SPECIFY.

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5. HAVE YOU EVER USED (OR ARE CURRENTLY USING) ACCUTANE? IF YES, PLEASE SPECIFY.

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6. HAVE YOU EVER HAD A CHEMICAL PEEL? IF YES PLEASE SPECIFY.

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7. HAVE YOU HAD ANY LASER TREATMENTS? IF YES, PLEASE SPECIFY.

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8. WHAT PRODUCTS ARE YOU CURRENTLY USING ON YOUR SKIN?

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9. DO YOU HAVE ANY DENTAL OR ACRYLIC IMPLANTS, CROWNS OR BRIDGEWORK? IF YES PLEASE SPECIFY.

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10. DO YOU HAVE ANY TATTOOS OR PERMANENT MAKEUP IN THE AREA TO BE TREATED? IF YES, PLEASE SPECIFY.

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11. DO YOU HAVE A PACEMAKER.

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12. HAVE YOU EVER BEEN TREATED BY AN ENDOCRINOLOGIST (HORMONE IMBALANCE) IF YES, PLEASE SPECIFY.

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13. DO YOU SUNBATHE OR USE SELF TANNING LOTIONS OR USE TANNING BEDS? IF SO, THEN HOW OFTEN?

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14. HAVE YOU EVER HAD GLOD THERAPY? (USED FOR RHEUMATOID ARTHRITIS)

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15. ARE YOU CURRENTLY PREGNANT?

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16. HAVE YOU HAD RESTYLANE, PERLANE, L, HYLAFORM OR BOTOX INJECTIONS IN THE AREA TO BE TREATED? IF YES, PLEASE SPECIFY.

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17. DO YOU HAVE ANY PARTICULAR SKIN SENSITIVITIES?

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PLEASE SIGN BELOW TO INDICATE ALL THE INFORMATION ON ALL FORMS ARE ACCURATE, TRUE AND COMPLETE.

Signature: \_\_\_\_\_ Print Name: \_\_\_\_\_

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_