

ABOUT FACE AESTHETICS & SKINCARE, LLC
MEDICAL HISTORY QUESTIONNAIRE

First & Last Name: _____ DOB: _____ Referred By: _____
 Address: _____ City: _____ State: _____ Zip: _____
 Home Phone: _____ Cell Phone: _____ Work Phone: _____
 Email Address: _____ May we contact you with special offers? _____

PERSONAL HEALTH HISTORY

For our female clients: Are you or could you be pregnant? Yes No Are you breastfeeding? Yes No
 Do you Smoke: ? Yes No.

Reason For Visit: _____

<input type="checkbox"/> Easy Bruising	<input type="checkbox"/> Pigmentation Disorder	<input type="checkbox"/> HIV/AIDS	<input type="checkbox"/> Keloid Formation/Scarring
<input type="checkbox"/> Herpes/Cold Sores/Fever Blisters	<input type="checkbox"/> Very Sensitive Skin	<input type="checkbox"/> Heart Condition	<input type="checkbox"/> Pacemaker/Defibrillator
<input type="checkbox"/> Melanoma/Skin Cancer	<input type="checkbox"/> Acne (Within Last 6 Months)	<input type="checkbox"/> Permanent Makeup/Tattoo	<input type="checkbox"/> Endocrine/Hormone Issues
<input type="checkbox"/> Skin Condition Not Listed:	<input type="checkbox"/> Diabetes (Type?)	<input type="checkbox"/> Lupus	<input type="checkbox"/> Hepatitis (List Type):

MEDICATIONS & ALLERGIES

List any allergies:	List any medications vitamins or herbal supplements that you are currently taking:
List any medical conditions:	Are you taking or have a recent history of taking: <input type="checkbox"/> Aspirin/Motrin/Advil/Coumadin/Herparin <input type="checkbox"/> Antibiotics <input type="checkbox"/> Accutane or other Retinoid? If yes, how recent? _____

PREVIOUS COSMETIC PROCEDURES (Circle all that apply)

Botox, Dysport or Xeomin	Vein Therapy
Juvederm or Other Fillers	Photo Rejuvenation (IPL/BBL)
Microdermabrasion	Laser Facial
Chemical Peel	Surgery (List)
Permanent Hair Removal (area?)	Previous Hospitalizations (List)
What did you like about these procedures?	
What were you dissatisfied with?	

SKIN TYPE

<input type="checkbox"/> Always burns. Never tans.	<input type="checkbox"/> Sometimes burns. Sometimes tans.
<input type="checkbox"/> Usually burns. Sometimes tans.	<input type="checkbox"/> Always tans

I certify that the preceding medical, personal and skin history statements are true and correct. I am aware it is my responsibility to inform the Nurse Practitioner or other staff of my current medical or health conditions and to update this history.

Patient Signature: _____ Date: _____

Tech/Esthetician Signature: _____

MD/NP Signature: _____