Medical History

Date:_____

Patient Name (Last/First):_____ DOB:_____

1. Allergies:

	Yes	No		Yes	No
Xylocaine:	_____	_____	Latex:	____	____
Cow's Milk:	_____	_____	Aspirin:	____	____

Other:_____

2. Medications:

Current Medication Regimen (Medication/Dose /Frequency):

_____

_____

_____

Do you take any of the following medications?:

	Yes	No	
Aspirin or Excedrin	____	____	
Plavix	____	____	
Coumadin	____	____	
Blood Thinner	____	____	If yes, name of blood thinner:_____
NSAIDS (Motrin/Advil)	____	____	If yes, how often?_____ How much?_____
Herbal Supplements	____	____	If yes, which ones?_____
Fish Oil	____	____	
Multivitamin	____	____	
Retin A	____	____	If yes, how often & where?:_____
Accutane	____	____	
Antibiotics	____	____	If yes, name of antibiotic:_____

3. Dermatologic History (please indicate those conditions with which you have been previously diagnosed):

	Yes	No		Yes	No	
Acne	____	____	Keloids	____	____	
Blistering Sunburn	____	____	Lupus	____	____	
Chicken Pox	____	____	Moles	____	____	
Dry Skin	____	____	Psoriasis	____	____	
Eczema	____	____	Rosacea	____	____	
Hair Thinning/Loss	____	____	Shingles	____	____	
Herpes Simplex (fever blisters)	____	____	Skin Cancer	____	____	If Yes, what type?:_____ & treatment;_____

Last Examination by a dermatologist: Date: _____ For: _____

4. **Medical History** (please indicate those conditions with which you have been previously diagnosed):

	Yes	No		Yes	No	
Anxiety	____	____	HIV/AIDS	____	____	
Arthritis	____	____	Kidney Disease	____	____	
Breast Cancer	____	____	Multiple Sclerosis	____	____	
Cancer Other	____	____	Myasthenia Gravis	____	____	
If yes, type: _____			Other Neuromuscular Disorder	____	____	If yes, type: _____
Diabetes	____	____	Seizure Disorder	____	____	
Fainting	____	____	Stroke	____	____	
Heart Disease	____	____	Thyroid Disease	____	____	
Hepatitis	____	____	Other;_____			

5. Other Essential Medical Information:

	Yes	No		Yes	No	
Pacemaker	____	____	Artificial Joints/Screws	____	____	
Defibrillator/ICD	____	____	Problems with bleeding	____	____	
Artificial heart valves	____	____	Any other metal implants?	____	____	If yes, where?_____

6. Surgical History: Please list prior surgeries and dates:

_____ _____

_____ _____

7. Family History:

	Yes	No	
Skin Cancer	____	____	If yes, type of cancer:_____
Other Cancer	____	____	If yes, type of cancer:_____

8. Women's Health

Are you pregnant?	Yes	No	Trying	NA
Are you Breastfeeding?	Yes	No		NA
When was your last menstrual period?	_____/_____/_____			NA

9. Cosmetic Dermatology

Do you smoke?	No	Former	Current
Do you sunbathe?	No	Former	Current
Do you use sunscreen daily?	No	Yes	
Do you use tanning beds?	No	Yes	
Do you wear contacts?	No	Yes	
Do you have problems with skin/wound healing?	No	Yes	
Do you develop keloids or thick scars?	No	Yes	
Do you wax or use hair removal creams?	No	Yes	
During pregnancy, did you get hyperpigmentation or masking?		No	Yes

How often do you experience blackheads, whiteheads or blemishes?

Never Occasionally Frequently All the time

What skin care products are you currently using?:_____

_____

Please circle whether you have had the following procedures?

Botox/Dysport/Xeomin:	If yes, when?_____	What area?_____
Dermal Fillers:	If yes, when?_____	What area?_____
Laser Treatment:	If yes, when? _____	What area? _____
Chemical Peel:	If yes, when? _____	What area?_____

10. **CONSENT AND AGREEMENT**: I certify that the above statements are true and correct and that I have been fully advised concerning the nature of the proposed treatments to be administered. I do hereby authorize and direct *Practically Perfect, Inc*. and/or *Facial Techniques, Ltd.* to administer such procedures as may be deemed *elective*. My signature below constitutes my acknowledgement that:
(1) I have read, understand and fully agree to the foregoing consent;
(2) The proposed treatment process has been satisfactorily explained to me and I have all the information I desire
(3) I hereby give my consent and authorization and release *Practically Perfect, Inc* and *Facial Techniques, Ltd.* and its agents of any future claims that I may have in connection with the described treatments.

Patient signature_____ Date:_____

Reviewed by:_____ Date:_____

Reviewed by:_____ Date:_____

Reviewed by:_____ Date:_____

Reviewed by:_____ Date:_____