**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): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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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**

LLast Examination by a dermatologist: Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ For: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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;\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**6. Family History: Yes No**

 Skin Cancer \_\_\_\_ \_\_\_\_ If yes, type of cancer:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Other Cancer \_\_\_\_ \_\_\_\_ If yes, type of cancer:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**7. Women’s Health**

 Are you pregnant? Yes No Trying NA

 Are you Breastfeeding? Yes No NA

 When was your last menstrual period? \_\_\_\_\_\_/\_\_\_\_\_\_\_/\_\_\_\_\_\_ NA

**8. 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:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_