



MEDICAL HISTORY QUESTIONNAIRE

Today's Date: ____/____/____

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

May we contact you by mail? (Please Circle One) Yes No

Home Phone: _____ Cell: _____

Work: _____ Other: _____

May we contact you by phone? (Please Circle One) Yes No

What telephone number should we use for care calls and confirming your appointment? _____

To whom may we send a thank you note for referring you to our clinic?

Would you like to be contacted via Email: (Please Circle One) Yes No

***Email Address (Must be completed for Botox Rewards Program):**

Date of Birth: ____/____/____ Gender: (Please Circle One) Male Female

Occupation: _____

Ethnicity: (Please Circle One) Asian African American Caucasian

Hispanic Native American Other: _____

Emergency Contact Person: _____

Emergency Contact Phone: _____

Are you under a Physician's or Dermatologist's care? (Please Circle One) Yes No

Name of Physician/Dermatologist: _____

Physician/Dermatologist Phone: _____

Please continue next page >>>

Medical & Surgical History

Do you have any allergies? (Please Circle One) Yes No

(If Yes, please list) _____

Do you currently take any medications (including over-the-counter meds)? (Please Circle One) Yes No

(If Yes, please list) _____

Please circle all that apply:

AIDS/HIV	Herpes Simplex/Cold Sores	Neurological Disorders
Asthma/Emphysema	Hirsutism	Polycystic Ovarian Syndrome
Autoimmune Diseases	Hypertension	Seizure Disorder
Blood Disorders	Kidney Disease	Shingles/Zoster
Diabetes	Liver Disease	Thyroid Disorders

Cancer (please state type, if none please notate) _____

Skin Disorders (please state type, if none please notate) _____

Other Medical Issues (please state, if none please notate) _____

Surgery (include cosmetic procedures & dates, if none please notate): _____

Non-surgical cosmetic procedures (if none please notate): _____

Do you have a pacemaker or implanted defibrillator? (Please circle one) Yes No

Do you have any metal pins, plates, dental fillings, etc.? (Please circle one) Yes No

Do you wear contact lenses? (Please circle one) Yes No

Are you currently pregnant or breast feeding? (Please circle one) Yes No

Have you taken Accutane? (Please circle one) Yes No

If yes, when? _____

Have you ever used Retin-A? (Please circle one) Yes No

If yes, when? _____

Current products used on the skin: _____

Have you ever had Gold Therapy? (Please circle one) Yes No

If yes, when? _____

Are you prone to Keloid Scarring? (Please circle one) Yes No

Do you have any tattoos or permanent makeup? (Please circle one) Yes No

If yes, where? _____

When was the last time you used depilatories (cream hair removers)? _____

When was the last time you tweezed? _____

When was the last time you used a self-tanner? _____

Have you had Vein Therapy? (Please circle one) Yes No

If yes, what type? _____ Date: _____

Patient Signature: _____ Date: _____

Medical Esthetician Sign: _____ Date: _____

Physician Signature: _____ Date: _____