CLIENT INFORMATION & MEDICAL HISTORY

In order to provide you with the most appropriate treatment, we need you to complete the following questionnaire. **All information is strictly confidential.**

Personal Information

Name _____ Date _____

Date of Birth _____ Age _____ Occupation _____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____ Email _____

What is the best number to call you at? _____

Emergency Contact: Name _____ Phone _____

How were you referred to us? _____

Medical History

Are you currently under the care of a physician? Yes ☐ No ☐

If yes, for what? _____

Do you have any of the following medical conditions? (Please mark yes or no to all)

Please check all that apply:	YES	NO		YES	NO
Cancer			Diabetes		
High Blood Pressure			Herpes		
Arthritis			Frequent cold sores		
HIV/AIDS			Keloid scarring		
Skin disease			Skin Lesions		
Seizure Disorder			Hepatitis		
Hormone Imbalance			Thyroid Imbalance		
Blood Clotting Abnormalities			Any active infection		
Heart Conditions					
Are you pregnant or trying to get pregnant?			Are you breastfeeding?		
Are you using contraception?			Birth control pills		
NEUROLOGICAL DISEASES:			Parkinson's		
Myasthenia Graves			Multiple Sclerosis (MS)		
Lambert-Eaton Syndrome			Amuotrophic Lateral Sclerosis (ALS)		

What oral prescription medications are you presently taking? _____

What antibiotics do you use to treat infections? _____

Are you presently taking any of the following medications or supplements listed below?

	YES	NO		YES	NO		YES	NO
Aspirin			Blood Thinners			Hormones		
Mood Altering Medication			Anti-Depression Medication			Vitamin E		
Fish Oil			Omega 3 Fatty Acids			Ginkgo Biloba		
Garlic			Ginger			Cayenne		
Licorice			Flax Seed Oil			COQ10		

Have you ever had an allergic reaction to the following?

☐ Food ☐ Animal Protein ☐ Aspirin ☐ Lidocaine (Anesthetic) ☐ Hydrocortisone

☐ Eggs ☐ Latex ☐ Hydroquinone or skin bleaching agents

Medications: _____

Others: _____

Facial History

1) What bothers you most about your facial appearance? _____

2) What are your expectations for today's visit? _____

Do you regularly sun bathe or use tanning salons? _____ How often? _____

What topical medications or creams are you currently using? ☐ RetinA ☐ Other

(Please list): _____

Have you waxed, tweezed, bleached or used hair removal cream withing the last week? ☐ Yes ☐ No

If yes, please specify: _____

Have you ever had botox or dermal fillers? ☐ Yes ☐ No

If yes, When were you last treated: _____

Any complications? ☐ Yes ☐ No If yes, please specify: _____

Have you taken any Aspirin, Ibuprophen, Motrin, Tylenol, Fish Oil, Vitamin E, Blood Thinners, Alcoholic Beverages in the last ten days? ☐ Yes ☐ No

If yes, what? _____

Facial Injury Trauma History

1) Is there any history of facial surgery? ☐ Yes ☐ No

Describe: _____

2) Is there any recent history of trauma to the head or face? ☐ Yes ☐ No

Describe: _____

3) Any TMJ problems? ☐ Pain ☐ Clenching ☐ Grinding

Describe: _____

I certify that the preceding medical, medication and personal history statements are true and correct. I am aware that it is my responsibility to inform the doctor or other health professional of my current medical health conditions and to update this history. A current medical history is essential for the caregiver to execute appropriate treatment procedures.

Signature _____ Date _____