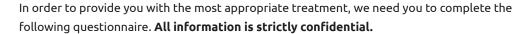
CLIENT INFORMATION & MEDICAL HISTORY





Personal Information

Licorice

Name									Date			
Date of Birth		A	.ge	(Occup	ation						
Address					City	y			State	Zip_		
Home Phone		c	Cell Phone	<u> </u>			E	mail_				
What is the best number to	call y	ou at	?									
Emergency Contact: Name									Phone			
How were you referred to u	us?											
Medical History												
Are you currently under the	e care	of a p	hysician?	Yes	s □ 1	No □						
If yes, for what?												
Do you have any of the foll									to all)			
					. (1	1		<i></i>				
Please check all that apply:				YES	NO						YES	NO
Cancer						Diabete						
High Blood Pressure						Herpes						
Arthritis						Freque			S			
HIV/AIDS						Keloid		ıg				
Skin disease						Skin Les						
Seizure Disorder							Hepatitis					
Hormone Imbalance						_	Thyroid Imbalance					
Blood Clotting Abnormalities						Any active infection						
Heart Conditions				-					l: 0			
Are you using contraception?							Are you breastfeeding? Birth control pills					
Are you using contraception? NEUROLOGICAL DISEASES:						Parkinson's						
Myasthenia Graves							Multiple Sclerosis (MS)					
Lambert-Eaton Syndrome							Amuotrophic Lateral Sclerosis (ALS)					
What oral prescription med	dicatio	ns are	e you pres	sentl	y taki							
What antibiotics do you use	e to tr	eat in	fections?									
Are you presently taking ar	າv of t	he fol	llowing m	edic	ations	s or supp	lemer	nts lis	sted below?			
		NO					VEC	NO	T		\	NO
A :-:-	YES	NO	Blood Th				YES	NO			YES	NO
·				pression Medication					Hormones			
Mood Altering Medication									Vitamin E			
Fish Oil			Omega 3) racc	y ACIÓ	5			Ginkgo Biloba			
Garlic			Ginger						Cayenne			

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? $\ \square$ RetinA $\ \square$ Other
(Please list):
Have you waxed, tweezed, bleached or used hair removal cream withing the last week? $\ \square$ Yes $\ \square$ No
If yes, please specify:
Have you ever had botox or dermal fillers? $\ \square$ Yes $\ \square$ 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? \Box Yes \Box No
If yes, what?
Facial Injury Trauma History
1) Is there any history of facial surgery? $\ \square$ Yes $\ \square$ No
Describe:
2) Is there any recent history of trauma to the head or face? $\ \square$ Yes $\ \square$ No
Describe:
3) Any TMJ problems? $\ \square$ Pain $\ \square$ Clenching $\ \square$ 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.
SignatureDate