PATIENT INFORMATION AND MEDICAL HISTORY

Name: _____ Date: _____

Full Address:_____City_____State____Zip_____

Cell Phone: _____ Alternate Phone:_____

Date of Birth:____/____/19____ Age: ____ Email: _____

HISTORY – Please circle if you have or have had :

Diabetes
Herpes – cold sores
Sensitive to anesthetic/lidocaine:
Lyme disease
Lupus
Heart problems or family history of heart problems?
Hysterectomy
Hypertension
Photosensitive disorder
Autoimmune illness
History of Bell's Palsy
Have you taken **accutane** in the past six months? Yes/No

Are you under the care of a physician? If yes, name: _____
Current/Recent medications: _____
Medical illness_____

	IF YES, EXPLAIN	
Cold sores	Yes	No
Keloid scars	Yes	No
Hives	Yes	No
Facial Skin Cancer	Yes	No
Facial waxing	Yes	No
Hypersensitivity to skin products	Yes	No
Skin infections	Yes	No
Laser skin resurfacing	Yes	No
Chemical Peels	**Yes**	**No**
Photo sensitizing substances	Yes	No
Laser work of any type	Yes	No
Complications from botulinum/fillers?	Yes	No

Are you pregnant or breastfeeding? Yes / No

Allergies of any kind, including drugs or gram-positive bacteria _____

Areas of interest for liquid facelift treatment: _____

I ATTEST THE ABOVE INFORMATION TO BE TRUE, KNOWING MY PROVIDER RELIES ON THIS INFORMATION TO PROVIDE SAFE AND EFFECTIVE TREATMENT. FOR THE SERVICES RECEIVED TODAY, I AGREE TO PAY $_____.

Adult Signature_____ Date_____