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ONE MIND. ONE BODY. ONE U.

Physicians of Aesthetic Medicine

Patient History

Last Name: ______________________________ First Name: __________________________
Address: ____
City: ______________________________ State: __________ Zip Code: ________________
Date of Birth: _____________________________ Sex: ❑ Female ❑ Male
Telephone: Home: ____________________________ Work: __________________________
Cell: ______________________________
Family Doctor: ________________________________ Phone: _________________________
Pharmacy: ____________________________________ Phone: _________________________
Emergency Contact: ____________________________ Phone: _________________________
*Email: ___________________________________ Referral Source: ___________________

**May we contact you regarding promotions, specials, or events? ____ Yes ___ No*

PRIVACY: We will only use your email address for internal marketing purposes

PLEASE ANSWER ALL OF THE FOLLOWING QUESTIONS:

1. **Do you have ANY current or chronic medical illnesses we should know about? If yes, please check appropriate boxes:** ❑ Yes ❑ No

❑ Asthma	❑ Pulmonary Embolus (PE)	❑ Deep Vein Thrombosis (DVT)
❑ Thrombophlebitis	❑ High Blood Pressure	❑ Heart Disease
❑ Heart Attack (MI)	❑ Diabetes	❑ Stroke
❑ Migraine	❑ Headaches	❑ Seizures or Convulsions
❑ Numbness	❑ Muscle Weakness	❑ Neurologic Disorder
❑ Fainting or Dizzy Spells	❑ ALS	❑ Myasthenia Gravis
❑ Autoimmune Disease	❑ Eye Disease	❑ Vision Problems
❑ Blood Transfusions	❑ Bleeding Disorders	❑ Cold Sores
❑ Hepatitis	❑ Anaphylactic Shock	❑ Septicemia
❑ Arthritis	❑ Easy Bruisability	❑ Hives
❑ Tumors/Cancer	❑ Skin Injury or Surgery	❑ Dark Spots after Pregnancy
❑ HIV Positive		

❑ Other: ____

2. **Do you take/use ANY medications, herbal or natural supplements, or topical on a regular or daily basis? If yes, please check the appropriate boxes:**

❑ Accutane	❑ Steroids	❑ Diabetes Medication
❑ Aspirin	❑ Doxycycline	❑ Ginko
❑ Coumadin (warfarin)	❑ Insulin	❑ Garlic
❑ Plavix	❑ Sedatives/Tranquilizers	❑ Vitamin A/E
❑ Thyroid Medication	❑ Appetite Suppressants	❑ Flax Seed Oil
❑ Chemotherapy Agents	❑ Cortisone	❑ Diet Pills
❑ Non-Steroidals (ex. Advil, Celebrex)		❑ Other ________________
❑ Steroids (Prednisone, Medrol Dose Pack)		

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3. **Have you taken *ANY* of the "as needed" medications listed below in the past 10 days? If yes, please check the appropriate boxes:**

- ❑ Aspirin
- ❑ Steroids
- ❑ Cortisone
- ❑ Non-Steroidals (ex. Advil, Celebrex)
- ❑ Steroids (Prednisone, Medrol Dose Pack)
- ❑ Other: ______________________________
- ❑ Doxycycline
- ❑ Appetite Suppressants
- ❑ Diet Pills
- ❑ Ginko
- ❑ Garlic
- ❑ Vitamin A/E

4. **Are you using any of the following topical products?**

- ❑ Retin-A®
- ❑ Renova®
- ❑ Tazorac®
- ❑ Avita®
- ❑ Alpha or Glycolic Acids
- ❑ Vitamin C

5. **Do you have *ANY* allergies? If yes, please check the appropriate boxes:**

- ❑ Eggs
- ❑ Foods
- ❑ Other: ______________________________
- ❑ Latex
- ❑ Nail Polish
- ❑ Medications
- ❑ Tape/Adhesives

6. **Medical History**

	Yes	No
(For women) Are you or could you be pregnant?	❑	❑
(For women) Are you lactating?	❑	❑
(For women) Are your menstrual periods regular?	❑	❑
Do you have a history of Herpes I or II in the area to be treated?	❑	❑
Do you have a history of keloid scarring?	❑	❑
Have you taken Accutane or anticoagulants in the last 6 months?	❑	❑
Do you have any permanent make-up, implants or tattoos? If yes, please list the locations: ______________________________	❑	❑
Have you had unprotected sun exposure, used tanning creams or tanning beds in the last 4-6 weeks?	❑	❑

7. **Family Hx:**

- ❑ Varicose Veins
- ❑ Vascular Disorders
- ❑ Cancer
- ❑ Strokes
- ❑ Leg Ulcers
- ❑ Bleeding Disorders
- ❑ Diabetes
- ❑ Thyroid Disorders
- ❑ Phlebitis
- ❑ Blood Clots
- ❑ Heart Attacks
- ❑ High Blood Pressure

8. **Social History:**

Do you smoke?	❑ Yes	❑ No	If yes, how much? ______________________
Do you drink alcohol?	❑ Yes	❑ No	If yes, how much? ______________________
Do you exercise?	❑ Yes	❑ No	
Occupation:			______________________

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9. **Please indicate which of the following concerns you have about your skin:**

- ❑ Aging Skin
- ❑ Redness
- ❑ Rosacea
- ❑ Sun Damage
- ❑ Skin Laxity
- ❑ Skin Texture/Tone
- ❑ Fine Lines/Wrinkles
- ❑ Facial Veins
- ❑ Pigmentation
- ❑ Acne
- ❑ Scars
- ❑ Hair Removal
- ❑ Dry Skin
- ❑ Spider Veins (legs)
- ❑ Stretch Marks
- ❑ Other: ________________

10. **Please indicate a service you are interested in or would like more information on:**

- ❑ Botox® /Dysport® for frown lines, crow's feet and forehead lines
- ❑ Dermal Fillers for wrinkles (Juvederm®, Radiesse®, Perlane®, Belotero®, Restylane®)
- ❑ IPL Photo Rejuvenation to produce younger, healthier looking skin through light therapy
- ❑ Sunspot Removal
- ❑ Microdermabrasion to gently and physically exfoliate the skin for a more even complexion
- ❑ Clear and Brilliant Laser® to improve tone and texture and give the skin a more radiant, youthful glow.
- ❑ Permanent Hair Reduction
- ❑ Chemical Peels –chemically exfoliates and resurfaces the skin for a more even complexion
- ❑ Sclerotherapy® for the treatment of Leg Veins
- ❑ Skin Tightening to tighten skin and help reverse the signs of aging

11. **Have You Ever Had Any of the Following Treatments?**

___ Botox® or Dysport® — Date of last treatment? ________________

___ Dermal Filler — Type, area and date of last treatment? ________________

___ Intense Pulsed Light — Date of last treatment? ________________

___Microdermabrasion — Date of last treatment? ________________

___Chemical Peel (Type) __________ — Date of last treatment? ________________

___Laser Hair Removal — Area and date of last treatment? ________________

___Laser Treatments — Type of laser, treated area, and to improve what? _________

____

___Sclerotherapy — Date of last treatment? ________________

___Cosmetic Surgery — Type and date of surgery: ________________

12. **Skin Care**:

Do you have a regular skin care regimen? ___ Yes ___ No Products used: ________________

Do you regularly wear sunscreen? ___ Yes___ No

Do you feel that your products are successfully treating your skin conditions and concerns? ____ Yes ____ No

____

Printed Client Name:

____ ________________

Client Signature Date