Medical Aesthetics Patient Intake Health Assessment

Name of Patient:____ Age: ____________

Address: ____ City ___________________ PC____________

Tel#:______________________________ Email:____

Please help us to assist in your suitability for aesthetic treatments by answering the following health related questions. Please check either **YES** or **NO** beside each condition that applies to you.

CONDITION	YES	NO	CONDITION	YES	NO
Contact Lenses			Heart Disease		
Bridge Work/Fillings/Braces			Skin Cancer		
Anaphylatic Shock (Allergic Reaction)			Other Cancer Type________________		
Allergies List:			____Hormone Replacement Therapy ____Testosterone Therapy		
___Asthma ____ Sinus Conditions			Edema / Swelling / Water Retention		
Ear Aches / Infections			Osteoarthritis / Rheumatoid Arthritis		
Acne or Problem Skin			Hepatitis		
____Sensitive Skin ____ Rosacea			Post Partum / Breast Feeding		
Recent Exposure to Sun / UVR			Pregnant, ____# Months		
Recent Tanning Bed Exposure			Hysterectomy / Ovaries Removed		
Sun / Heat Sensitivity			Claustrophobia		
Sunless / self tanner use			Polycystic Ovarian Syndrome (PCOS)		
Vitligo / Hypopigmentation			Thyroid disorder / imbalance		
Hyperpigmentation / pigment spots			Adrenal Gland Disorder		
Dermatitis / Rashes / Eczema / Hives			Epilepsy		
Psoriasis			Fibromyalgia		
Cold Sores / Fever Blisters			Keloid Scars		
Genital Herpes			Tuberculosis		
Varicose Veins / Spider Veins			HIV+ / AIDS		
Bruise Easily			Auto-immune disorders - lupus, MS		
_____High _____Low Blood Pressure			Stress / Anxiety		
Pace Maker			Permanent Make-up		
Phlebitis			Hair Bleaching (face or arms only)		
Diabetes			Circulation or Lymphatic Problems		
Other:			Other:		

Please indicate which of the following you have used in the last **6-months:**

- ☐ Antibiotics Name: ____________________
- ☐ Prescription acne or other skin care medication Name: ____________________
- ☐ Photosensitizing Medications Name: ____________________
- ☐ Retinol
- ☐ Accutane
- ☐ Glycolic Acid, Salicylic Acid or other chemicals for exfoliating the skin
- ☐ Hormone Therapy (Birth control, hormone replacement)
- ☐ Fish Oils / Omega 3
- ☐ Vitamin E
- ☐ Advil, Motrin , Asprin

List current skin care products:

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Please indicate which of the following treatments you have had in the past:

- ☐ Derma Filler (Juvederm, Restylane, Teosyal)
- ☐ Botox, Dysport, Xeomin

Please list any complications or concerns you had with any of these treatments (if applicable):

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____

Have you had any of the treatments below: (please circle one)

Microdermabrasion	YES	NO
Laser Hair Removal	YES	NO
Laser Spider Vein Removal	YES	NO
Sclerotherapy (injections)	YES	NO
Photo Rejuvenation	YES	NO
Electrolysis	YES	NO
Other laser or light therapy treatments	YES	NO
Have you had any anesthetic procedures	YES	NO

I am aware that it is my responsibility to disclose any and all medical conditions and health related concerns prior to receiving treatment in order to prevent any possible health related or other risks to myself. In consideration to this clinic, agreeing to provide me with treatments specified above, I agree not to hold liable this clinic, their employees or contractors for any damage, including with limitation, personal or bodily injury of any kind, allergies,reactions, or illness that I may sustain as a result of any of the para-medical tretments carried out. I hereby waive any rights I may have or acquire to make any claim against this clinic in connection with the forgoing and I expressly release this clinic from any liability with respect thereto.

____________________________ ____________________________

Patient Signature Date

____________________________ ____________________________

Physician / Technician Signature Date