Health Questionnaire

Name_____ Today's Date _____

Age_____ Date of Birth_____ Email_____

Primary Phone Number _____ Pharmacy/Address _____

Emergency Contact_____ Number _____

Primary Care Physician_____ Phone Number_____

MEDICAL INFORMATION

Are you under the care of a physician? If yes, please explain._____

Allergies □ None

Bee/Wasp/Latex/Other Allergy_____ Reaction_____

Medications

Past/Current Conditions/Treatments

□ Diabetes	□ Hypertension	□ Cold Sores	□ Irregular Menses
□ Hepatitis	□ Keloid Scars	□ Skin Infections	□ Heart Problems
□ Herpes	□ Hive	□ Use of acne products	□ Photosensitive Disorder
□ Menopause	□ Skin Cancer	□ Chemical Peels	□ Autoimmune Illness
□ Lupus	□ Waxing	□ Use of Acne Products/Drugs	□ Tanning within the lass 6 weeks
□ Hysterectomy	□ Electrolysis	□ Hypersensitivity to Skin Product	□ Laser work of any kind

If Yes, Please Explain_____

Do you smoke or use tobacco? No Yes
Do you drink alcohol? No Yes Drinks per week_____
Do you use recreational drugs? No Yes
Are you pregnant?_____ Medical Illness_____

Which areas are of concern to you?

□ Forehead	□ Cheeks	□ Loose skin
□ Brow	□ Neck	□ Aging skin
□ Eyelids	□ Skin	□ Other
□ Lips	□ Nose	_____
□ Chin	□ Ears	

Past Facial Treatments

□ Botox, Xeomin, Dysport
□ Injections or Fillers
□ Laser treatments
□ Facial surgery
□ Accutane
□ Other _____

Who can we thank for your referral?_____

I ATTEST THE ABOVE INFORMATION TO BE TRUE, KNOWING MY PROVIDER RELIES ON THIS INFORMATION TO PROVIDE SAFE AND EFFECTIVE TREATMENT.

Patient Signature_____**Date**_____