

Health Questionnaire

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone Cell: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Home: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_

How did you hear about us? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

HEALTH HISTORY

Do you have a history of?

(Circle all that apply)

Auto-Immune Disease

Neurological-Musculoskeletal Disease

Heart Disease

Thyroid Disease

Liver Disease

Kidney Disease

Diabetes

Cancer

Bleeding Disorder

HIV/AIDS

Hormone Imbalance

TMJ/Jaw pain

Spider Veins

Excessive brusing bleeding with injections

Cold Sores

Are you currently ill, or do you have any infections such as UTI, cold, cold sore, or are you taking any antibiotics? Y or N

Are you? Pregnant Y or N Nursing Y or N

Do you? Smoke Y or N Drink Alcohol Y or N Amount per week \_\_\_\_\_\_\_\_

Have you had facial surgery? Y or N

Have you had Botox/Dysport injections done? Y or N

If yes, did you have any adverse reactions and what were they?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you had dermal fillers done in the past (Juvederm, Restylane)? Y or N

If yes, did you have any adverse reactions and what were they?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever been treated with Accutane? Y or N

Do you have any known allergies? (asthma, allergies to medications, foods, cosmetics, latex)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medications (prescription, over the counter, supplements, vitamins, herbs):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Have you taken any blood thinning products over the past 2 weeks including: aspirin, Eliquis, Pradaxa, Savaysa, Xarelto, Warfarin, Coumadin, NSAIDS, Meloxicam, Mobic, ibuprofen, Aleve, tumeric, ginger, garlic, fish oil, cinnamon, cayenne, Vitamin E, echinacea? Y or N

Have you had laser, chemical peels, or microneedling done in the past? Y or N

If yes, did you have any adverse reactions and what were they?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

WHAT MEDICAL AESTHETIC PROCEDURES ARE YOU INTERESTED IN?

(Circle all that apply)

Vampire Facelift or facial (PRP)

O-Shot

PRP Hair restoration

Botox

Dermal fillers or Sculptra

Sclerotherapy/spider vein treatments

Treating acne or acne scars

Treating fine lines and wrinkles

Restoring volume to the face

Microneedling (Collagen Induction Therapy)

Skin care advice/recommendation of skin care products

Medical grade chemical peels

Latisse

B12 injections

Removing moles, skin tags, or warts

Treating stretch marks or scars

What skin care products are you currently using?

Cleanser\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Toner\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Treatment products\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Serums\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Moisturizer\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Prescription skin care products\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you currently using sunscreen on your face a daily? Y or N

The above information is true and accurate to the best of my knowledge

Patient Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_