



1. **Please list all present medications**, including **Accutane**, **birth control pills**, hormones, and vitamins, **herbal** supplements, diuretics, **weight loss drugs**, **energy drinks**. Also, **topical** skincare medications or creams including tretinoin (Retin-A), Differin, Metro-gel, etc. **Include over-the-counter medications.**

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2. Have you ever had an adverse reactions to any skin related procedures or cosmetics?  Yes  No  
Which? \_\_\_\_\_

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3. Do you have a history of cold sores or fever blisters?  Yes  No Date of last outbreak? \_\_\_\_\_

4. What is your ethnic background (for purposes of aesthetic treatments)? \_\_\_\_\_

5. In response to sun exposure, do you typically tan or burn? \_\_\_\_\_

Would you consider yourself to have a tan at this point in time?  Yes  No

6. Do you have cocktails regularly, or consume regular amounts of alcoholic beverages, including beer, wine, or other alcohol?

Yes  No If so, how much? \_\_\_\_\_

7. Do you smoke or use any **Nicotine** containing products (i.e. gum, patch, etc)?  Yes  No

If so, how much? \_\_\_\_\_ For how long? \_\_\_\_\_

8. Are you pregnant or breastfeeding?  Yes  No

9. Are you actively trying to become pregnant currently or in near future?  Yes  No

10. Are you using, or have you used **Accutane** within the past 12 months?  Yes  No

11. When was you last normal menstrual period? \_\_\_\_\_

**\* IF YOU ARE TO BECOME PREGNANT, BE SURE TO LET OUR OFFICE KNOW IMMEDIATELY. THIS WILL ALLOW FOR THE PROPER ALTERATIONS IN YOUR SERVICE OR PRODUCT USE TO BE MADE. SOME PROCEDURES OR PRODUCTS ARE CONTRAINDICATED WITH PREGNANCY OR BREAST FEEDING AND MAY BE HARMFUL TO YOUR CHILD! (i.e. Retin-A, Hydroquinone, etc...)**

12. When was your last eye exam? \_\_\_\_\_ By whom? \_\_\_\_\_

13. When was your last physical exam? \_\_\_\_\_ By whom? \_\_\_\_\_

14. When was your last chest x-ray? \_\_\_\_\_ EKG? \_\_\_\_\_

15. Have you had any recent blood work done?  Yes  No When? \_\_\_\_\_

16. Please list all physicians presently caring for you & their office phone numbers: \_\_\_\_\_

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17. Have you ever been under psychiatric care?  Yes  No When? \_\_\_\_\_  
Why? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

18. Please list all hospitalizations, surgeries and procedures, including cosmetic: (include where, when and why for each):  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

19. What are your expectations for your appointments with us? \_\_\_\_\_  
\_\_\_\_\_

20. Do you understand that there is no such thing as “perfection” and that the goal of any cosmetic procedures is “improvement?”  Yes  No

21. Are you generally a happy and optimistic person?  Yes  No

22. Do you understand that there are risks associated with all procedures such as infection, allergic reaction, scarring, asymmetry, need for further procedures, dissatisfaction with results, permanent disfigurement, etc?  Yes  No

23. Do you understand that it is your responsibility to update your information with us - such as name or number changes, allergy, medication or medical history changes, and inform us of any such change?  Yes  No

**By signing below, I agree that the above information is complete and accurate to the best of my knowledge.**

Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
**(If under 18 then signature and name of parent or guardian)**

Print Name: \_\_\_\_\_

**\*Use additional paper or attach additional forms if necessary. Please print legible and complete all fields.\***