

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.**

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

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. 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...)**

11. When was your last eye exam? _____ By whom? _____

12. When was your last physical exam? _____ By whom? _____

13. When was your last chest x-ray? _____ EKG? _____

14. Have you had any recent blood work done? Yes No When? _____

15. Please list all physicians presently caring for you & their office phone numbers: _____

16. Have you ever been under psychiatric care? Yes No When? _____
Why? _____

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

18. What are your expectations for your appointments with us? _____

19. Do you understand that there is no such thing as “perfection” and that the goal of any cosmetic procedures is “improvement?” Yes No
20. Do you understand that there are risks associated with all procedures such as infection, allergic reaction, scarring, asymmetry, need for further procedures, etc? Yes No
21. 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.