PERSONAL PROFILE AND HEALTH HISTORY

Last Name **First Name** **Middle Name**

Street Address

City **State** **Zip**

Home Phone **Work** **Cell**

E-mail **Occupation** **Date of Birth**

Primary Care Physician **Phone**

How did you hear about us?

PLEASE SPECIFY YOUR GENETIC ORIGIN

☐ African American ☐ Asian ☐ Caucasian ☐ Hispanic ☐ Mediterranean ☐ Native American ☐ Other: _____

FEMALES

Are you pregnant?	**YES**	**NO**
Are you breastfeeding?	**YES**	**NO**
Are you planning pregnancy during the course of your treatment?	**YES**	**NO**
During pregnancy did you develop hyperpigmentation or masking?	**YES**	**NO**
Do you have regular periods?	**YES**	**NO**
Are you going through menopause?	**YES**	**NO**

Please list all medications including prescription and over the counter drugs, vitamins, herbs, supplements below.

Are you using any medications purchased outside the USA?	**YES**	**NO**
Are you allergic to any medications, foods, products? If yes, please list below.	**YES**	**NO**

MEDICAL HISTORY: *Please check all that apply*

☐ Acne	☐ Endocrine disorders	☐ Hirsutism	☐ Polycystic ovary disease	☐ Thyroid disease
☐ Bleeding disorders	☐ Filler injections	☐ Hormone replacement Rx	☐ Psychiatric Conditions/Depression	☐ Transplants
☐ BOTOX cosmetic	☐ Gold therapy	☐ Implants	☐ Psoriasis/Eczema	☐ Vitiligo
☐ Burns/Skin Grafts	☐ Heart disease	☐ Kaposi's sarcoma	☐ Rosacea	☐ Pacemaker
☐ Cancer	☐ Hemorrhoids	☐ Kidney disease	☐ Seizures	☐ Cold sores/fever blisters
☐ Cardiac conditions	☐ Herpes	☐ Keloid scars	☐ Shingles	☐ HIV / AIDS
☐ Diabetes	☐ Hepatitis	☐ Lupus erythematous	☐ Skin cancer	☐ Metal or other implants
☐ Diastasis Recti	☐ Hernia(s)	☐ Liver disease	☐ Radiation/Chemotherapy	☐ Other:
☐ Eating disorders	☐ High Blood Pressure	☐ Permanent makeup	☐ Tattoos	

List any cosmetic procedures or surgeries above.

PERSONAL PROFILE AND HEALTH HISTORY

PLEASE ANSWER THE FOLLOWING QUESTIONS

1. Are you currently being treated for any medical condition(s)?	**YES**	**NO**
If **YES**, *please explain:*		
2. Have you ever seen a physician regarding your skin?	**YES**	**NO**
3. Do you have any active skin disesases or infection in the area to be treated?	**YES**	**NO**
4. Do you have any skin allergies?	**YES**	**NO**
5. Have you had skin cancer or pre-cancerous lesions?	**YES**	**NO**
6. Do you have psoriasis/eczema in the area to be treated?	**YES**	**NO**
7. Are there any moles with hair in the area to be treated?	**YES**	**NO**
8. Are you allergic to latex, lidocaine, or any lotions?	**YES**	**NO**
9. Have you ever had surgery in the area to be treated?	**YES**	**NO**
10. Have a history of Diastasis Recti?	**YES**	**NO**
11. Have a history of Hernia/Hernia repair?	**YES**	**NO**
12. Have you any previous laser treatments or other skin treatments to the area to be treated?	**YES**	**NO**
Describe:		
13. Have you/are you using medications such as Accutane?	**YES**	**NO**
Date of last use:		
14. Are you using Retina-A, Renova, Differein, Tazorac?	**YES**	**NO**
Concentration _____%		
15. Are you using glycolic/AHA home care products?	**YES**	**NO**
16. What skin care products are you currently using?	**YES**	**NO**
Please list:		
17. Do you smoke?	**YES**	**NO**
18. Do you sunbathe?	**YES**	**NO**
If yes, when was your last exposure?		
19. Are you currently using, or have you used a tanning bed or self tanner?	**YES**	**NO**
If yes, when was your last exposure/use?		
20. Do you use sunblock?	**YES**	**NO**
21. Do you use depilatories or hot wax?	**YES**	**NO**
22. Does your skin remain discolored after healing from a cut?	**YES**	**NO**

PLEASE INDICATE WHICH OF THE FOLLOWING CONCERNS YOU HAVE ABOUT YOUR SKIN/BODY?

☐ Aged skin	☐ Sun damage	☐ Rosacea	☐ Age spots	☐ Spider veins	☐ Dry / Sensitive skin
☐ Acne	☐ Enlarged pores	☐ Blackheads	☐ Texture	☐ Scars	☐ Double Chin
☐ Redness	☐ Wrinkles	☐ Whiteheads	☐ Melasma	☐ Uneven skin color	☐ Skin laxity
☐ Leg veins	☐ Hair removal	☐ Oily skin	☐ Cellulite	☐ Pigment changes	☐ Stubborn fat/pinchable fat

PLEASE INDICATE THE SERVICE(S) YOU ARE INTERESTED IN OR WOULD LIKE MORE INFORMATION ON:

☐ Laser skin rejuvenation	☐ Rosacea treatment	☐ Acne treatment	☐ Pigment treatment	☐ Filler injections	☐ Melasma
☐ Laser vein treatment	☐ Sun damage repair	☐ Age spot treatment	☐ Wrinkle treatment	☐ Redness/vessel	☐ Fat reduction/CoolSculpting
☐ Laser hair removal	☐ BOTOX cosmetic	☐ Skin tightening	☐ Scar treatment	☐ Skin resurfacing	☐ Other:

I confirm that the answers to the questionnaire are true and correct.

Client Signature **Date**

Medical Professional's Signature **Date**

Medical Director's Signature **Date**

This form must be completed for all new clients. BOTOX is a registered trademark of Allergan, Inc.