HEALTH HISTORY

Todays Date: __________________ Date of Birth (mm/dd/yyyy) ____________________ Age _____ Sex : □ F □ M

Last Name: ____________________________________ First: _____________________ M.I.: ________

Street Address: ______________________________City: ________________ State: ______ Zip __________

Cell Phone _________________________________ Home Phone ________________________________

Please provide Email to receive monthly specials ____

Occupation:___________________________ WHERE DID YOU HEAR ABOUT US? (Please be specific):_________________________

SHOULD PRESCRIPTIONS BE PRESCRIBED, PLEASE LIST YOUR PHARMACY:____

PRIMARY CARE PHYSICIAN__________________________________ DERMATOLOGIST______________________________________

MEDICAL HEALTH HISTORY (Circle any condition for which you have ever been treated

KELOID SCARRING	MRSA INFECTION	DEPRESSION	SMOKER
HERPES (OR COLD SORES)	SEIZURES	HIGH BLOOD PRESSURE	LUNG DISEASE
AUTOIMMUNE DISORDER	KIDNEY DISEASE	ARTHRITIS / GOUT	HEART DISEASE
BLOOD DISORDERS	EASY BRUISING	HORMONAL IMBALANCES	CURRENTLY PREGNANT
CANCER / RADIATION THERAPY	PACEMAKER	HX OF ACCUTANE USE	POOR HEALING
DIABETES	SKIN DISEASE/CANCER	POLYCYSTIC OVARY SYNDROME	BLOOD CLOTS
HEPATITIS/HIV	SKIN GRAFT	NUMBER OF PREGNACIES_______	STEROID USE

LIST ALL MEDICATION ALLERGIES (including allergy to eggs)
****PLEASE NOTIFY YOUR HEALTH CARE PROVIDER IF YOU HAVE AN ALLERGY TO LATEX:**

LIST ALL CURRENT OR PAST HEALTH CONDITIONS:

LIST ALL SURGERIES:

LIST ALL MEDICATIONS INCLUDING ASPIRIN AND HERBAL SUPPLEMENTS;

HAVE YOU HAD PREVIOUS LASER TREATMENTS, BOTOX, FILLERS, COSMETIC PROCEDURES? (LIST)

HAVE YOU EVER HAD ANY COMPLICATIONS DUE TO ANY OF THE ABOVE (INCLUDING, BUT NOT LIMITED TO, FACIALS, EXTRACTIONS, AND MICRODERABRASION)