CLIENT INFORMATION & MEDICAL HISTORY

In order to provide you with the most appropriate treatment, we need you to complete the following questionnaire. All information is strictly confidential.

PERSONAL INFORMATION

Client Name_____ Date _____

Date of Birth _____ Age _____ Occupation _____

Home Address_____ City_____ State _____ Zip_____

Home Phone _____ Cell Phone_____ Email _____

What is the best number for you to receive a follow up call this evening?_____

Emergency Contact Name & Phone _____

How were you referred to us? _____

MEDICAL HISTORY

Are you currently under the care of a physician? YES / NO

If yes, for what?_____

Do you have any of the following medical conditions? (Please marke YES or NO to all)

PLEASE CHECK ALL THAT APPLY:	YES	NO		YES	NO
Cancer			Diabetes		
High Blood Pressure			Herpes		
Arthritis			Frequent cold sores		
HIV/AIDS			Keloid scarring		
Skin disease			Skin Lesions		
Seizure Disorder			Hepatitis		
Hormone Imbalance			Thyroid Imbalance		
Blood Clotting Abnormalities			Any active infection		
Heart Conditions					
Are you pregnant or trying to get pregnant?			Are you breastfeeding?		
Are you using contraception?			Birth control pills		
NEUROLOGIC DISEASES:			Parkinson's		
Myasthenia Graves			Multiple Sclerosis (MS)		
Lambert-Eaton Syndrome			Amuotrophic Lateral Sclerosis (ALS)		

What oral prescription medications are you presently taking? _____

What antibiotics do you use to treat infections? _____

Are you presently taking any of the following medication or supplements listed below?

	YES	NO		YES	NO	YES	NO
Aspirin			Blood thinners		Hormones		
Mood altering medication			Anti-depression medication		Vitamin E		
Fish Oil			Omega 3 fatty acids		Ginkgo biloba		
Garlic			Ginger		Cayenne		
Licorice			Flax seed oil		COQ10		

Have you ever had an allergic reaction to the following?

☐Food ☐Animal Protein ☐Aspirin ☐Lidocaine (Anesthetic) ☐Hydrocortisone

☐Eggs ☐Latex ☐Hydroquinone or skin bleaching agents

Others:_____

FACIAL HISTORY

1) What bothers you most about your facial appearance? _____

2) What are your expectations for today's visit? _____

Do you regularly sun bathe or use tanning salons? _____ How often? _____

What topical medications or creams are you currently using? ☐RetinA ☐Other

(Please list):_____

Have you waxed, tweezed, bleached or used hair removal cream withing the last week? YES / NO

If yes, please specify: _____

Have you ever had botox or dermal fillers? YES / NO

If yes, When were you last treated: _____

Any complications? YES / NO If yes, please specify:_____

Have you taken any Aspirin, Ibuprophen, Motrin, Tylenol, Fish Oil, Vitamin E, Blood Thinners, Alcoholic Beverages in the last ten days? YES / NO

If yes, what? _____

FACIAL INJURY TRAUMA HISTORY

1) Is there any history of facial surgery? YES / NO

Describe: _____

2) Is there any recent history of trauma to the head or face? YES / NO

Describe: _____

3) Any TMJ problems? Pain Clenching Grinding

Describe: _____

BRILLIANT DISTINCTIONS

Are you currently enrolled in the Brilliant Distinctions Program? YES / NO

If yes, please provide us with your member number: _____

If not, Brilliant Distinctions is a program that rewards you with savings on Allergan facial treatments and products, like Botox and Juvederm. Ask us for details on how to sign up.

I certify that the preceding medical, medication and personal history statements are true and correct. I am aware that it is my responsibility to inform the doctor or other health professional of my current medical health conditions and to update this history. A current medical history is essential for the caregiver to execute appropriate treatment procedures.

*Signature*_____ *Date* _____