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 _____
Phone _____ Email _____
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? _____

ALLERGIES

Do you have any allergies? (Medications, foods, creams etc.) Please list:
_____

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

Please Mark all that apply	Yes	No		Yes	No
Cancer			Are you pregnant or trying to get pregnant?		
High Blood Pressure			Are you breastfeeding		
Arthritis			Are you taking OCP/Contraception?		
HIV/AIDS			Hepatitis		
Skin Disease/Lesions			Thyroid problems		
Frequent cold sores/Herpes			Myasthenia Gravis		
Keloid Scarring			Lambert-Eaton syndrome		
Diabetes			Parkinson's		
Blood Clotting issues			MS (Multiple Sclerosis)		
Heart condition			ALS (Motor Neurone Disease)		
Other: Please document below:			SLE (Lupus) or RA (rheumatoid Arthritis)		

What medications are you currently taking? _____

Have you taken any Aspirin, Ibuprofen, Anti-Inflammatories, Fish Oil, Vitamin E, Blood Thinners, Alcoholic Beverages in the last week? YES / NO
If yes, what? _____

CLIENT INFORMATION & MEDICAL HISTORY

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? _____ How often? _____

What topical medications or creams are you currently using? ☐ Retin A ☐ Other
(Please list): _____
Have you waxed, tweezed, bleached or used hair removal cream within the las t week? YE S / NO
If yes, please specify: _____
Have you ever had wrinkle relaxers or dermal fillers? YES / NO
If yes, when were you last treated: _____
And what procedure did you have attended: _____
Any complications? YES / NO If Yes, Please specify:
_____
_____

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? YE S / NO
Describe: _____
3) Any TMJ/Jaw problems? Pain Clenching Grinding, do you wear/or have worn a retainer
Describe: _____

_____

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 and care.

Signature _____ *Date* _____