Medical History Form- Prescott Medical Aesthetics

Name____ Date ______________________

Home Address __________________________________ City: ___________ State: ______ Zip: _________

Phone number _____________________ Email Address __________________________________

Occupation________________________ Work phone____________________ D.O.B _________________

Emergency contact & phone #____

List all Medication, Food, and Makeup ALLERGIES____

List all medications you are taking: Prescription and Homeopathic as well as Retin A, Glycolic Acid & Acutane, Aspirin, Ibuprofen, Vitamins and all other Over the Counter Meds

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Have you ever had a MRSA/staph Infection? □Y □ N If yes, was the infection acquired in a hospital? □Y□ N

Do you take prophylactic premeds before having a procedure at the dentist □Y□ N, If so, what?___________

What products do you use for skin care? ____

Do you have any of the following conditions? (Check Yes or No)

□Yes □ No Cold Sores, when? _________ □Yes □ No Herpes Simplex Shingles, when? _____________

□Yes □ No Dry Eye- Use Drops? _________ □Yes □ No Corneal Abrasion, when? _________

□Yes □ No Eye Surgery/ Injury, when? _________

□Yes □ No Cataracts Visual Disturbances/ Glaucoma Wear Contacts Tumors/ Growths/ Cysts (Circle)

□Yes □ No Abnormal Heart Condition _______________

□Yes □ No High/ Low Blood Pressure (Circle)

□Yes □ No Circulatory Problems Fainting/Dizzy Spells (Circle)

□Yes □ No Hemophilia Prolonged Bleeding why? ________________

□Yes □ No Hepatitis _________ □Yes □ No Allergic to Cow's Milk Protein

□Yes □ No Diabetes? □Yes □ No Chemo/ Radiation (ever)?

□Yes □ No Use Tobacco Products? □Yes □ No Cosmetic Surgeries?

□Yes □ No Facial Cosmetic Surgery? □Yes □ No Using eye drops?

□Yes □ No Pregnant, or Nursing?

□Yes □ No Diagnosed with any peripheral motor neuropathic diseases that affect your muscles and nerves, such as: ALS, Lou Gehrig's Disease, Myasthenia Gravis or Lambert Eaton Syndrome.

□Yes □ No Have you had any type of Laser, Photofacial, Botox, Dysport, Restylane, Radiesse, Sculptra, Hylaform, Perlane, Collagen, Silicone, Juvederm, Artefill or any other Cosmetic/ Plastic Surgery Procedures performed on your face or have scheduled in the future? If so, Which procedure(s?) Where on your face? When performed or scheduled?)____

Were you pleased with your result(s?) /any complications/concerns?_______________________________

Any medical concerns about procedure(s) you are interested in today?______________________________

Any Other medical conditions? ____

Thank you for taking time to fill this out.

____________________________________ _________________________

Signature Date