INJECTABLE
AESTHETICS

CLIENT INFORMATION AND MEDICAL HISTORY

IN ORDER TO PROVIDE YOU WITH THE MOST APPROPRIATE, SAFE TREATMENT FOR YOU, WE NEED YOU TO COMPLETE THE FOLLOWING QUESTIONNAIRE. ALL INFORMATION IS STRICTLY CONFIDENTIAL.

PERSONAL HISTORY

Client Name_____Today's Date_____

Date of Birth_____Age_____Occupation_____

E-Mail _____

Home Address_____City_____State_____ Zip_____

Home Phone ( )_____Pharmacy (Name/Location)_____

Emergency Contact Name and Phone_____

How were you referred to us? _____

Have you had a previous treatment with Botox, Dysport, or Xeomin? ○ YES ◉ NO How long ago?_____

Have you had a previous treatment with a dermal filler? ◉ YES ○ NO How long ago? _____

Which of the following best describes your skin type? (Please circle one type number)

I ○ Always burns, never tans

II ○ Always burns, sometimes tans

III ○ Sometimes burns, always tans

IV ○ Rarely Burns, always tans

V ○ Brown, moderately pigmented skin

VI ○ African American skin

MEDICAL HISTORY

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

If yes, for what? _____

Are you currently under the care of a dermatologist? ◯ YES ◉ NO
If yes, for what: _____

SKIN CARE

When was your last facial? _____ What did you have done?_____

Do you use SPF?_____ When did you last exfoliate?_____

Describe your skin and list main concerns _____

_____

Do you have a history of erythema ab igne, which is a persistent skin rash produced by prolonged or repeated exposure to moderately intense heat or infrared irritation? ◯ YES ◯ NO

Do you have any of the following medical conditions? (Please check all that apply)

☐ 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 Skin Infection

Do you have any other health problems or medical conditions? Please list:

Do you have a metal implant, pace maker or metal piercings? ◉ YES ◯ NO

If yes, what? _____

Do you have a history of Neuromuscular Disorders? (Please check all that apply)

☐ Amyotrophic Lateral Sclerosis (LAS) ☐ Multiple Sclerosis ☐ Muscular Dystrophy

☐ Myasthenia Gravis ☐ Spinal Muscular Atrophy ☐ Bell's Palsy

Any known allergies? _____

Have you ever had an allergic reaction? (Check all that apply and describe the reaction your experience)

☐ Food ☐ Animal Protein ☐ Albumin (Eggs) products ☐ Aspirin ☐ Lidocaine

☐ Hydrocortisone ☐ Hydroquinone or Skin Bleaching Agents ☐ Others: _____

What oral medications are you presently taking? ☐ Birth Control Pills ☐ Hormones ☐ Other: _____

Are you on any mood altering or anti-depression medication? _____

Have you ever used Accutane? ◯ YES ◉ NO If yes, when did you use it last? _____

What topical medications or creams are you currently using? ☐ Retin-A ☐ Others (Please list):

_____

What herbal supplements do you use regularly? _____

Are you currently taking an antibiotic? If yes, please list: _____

Do you take any medications for heart conditions? If so, please list: _____

Are you taking anticoagulants or medications to thin your blood (i.e. Plavix, Coumadin Aspirin, Baby Aspirin)◯ YES ◉ NO If yes, please list: _____

Do you smoke?◯ YES ◯ NO If yes, how many packs per day/week? _____

Do you drink alcohol?◯ YES ◯ NO If yes, how much and how often? _____

HISTORY

Have you ever had laser hair removal?◯ YES ◯ NO

Have you used any of the following hair removal methods in the past 6 weeks?

☐ SHAVING ☐ WAXING ☐ ELECTROLYSIS ☐ TWEEZING ☐ STRINGING ☐ DEPILATORIES

Have you had any recent tanning or sun exposure that changed the color of your skin?◯ YES ◯ NO

Have you recently used any self-tanning lotions or had a spray tan?◯ YES ◯ NO

Do you form thick or raised scars from cuts or burns?◯ YES ◯ NO

Do you have Hyperpigmentation (darkening of the skin) or Hypopigmentation (lightening of the skin) or marks after physical trauma? ◯ YES ◯ NO If yes, please describe: _____

_____

PHOTOGRAPHY CONSENT

I authorize the use of my photographs for print and/or social media use (Facebook, Instagram, etc.)
◯ YES ◯ NO

_____

FOR OUR FEMALE CLIENTS ONLY:

Are you pregnant or trying to become pregnant? ◯ YES ◯ NO

Are you breastfeeding? ◯ YES ◯ NO

Are you using contraception? ◯ YES ◯ NO

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

Signature: _____Date: _____