



Medical Health History

Name: _____ Date: _____

Address: _____ City: _____ State _____ Zip _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Date of Birth: _____ SSN: _____ Employer: _____

Emergency Contact _____ Phone: _____

How did you hear about us? _____ Email: _____

Circle all that apply:

- Amyotrophic Lateral Sclerosis
- Anemia
- Arthritis
- Auto-Immune-Deficiency
- Asthma
- Bleeding Disorder
- Blood Disease
- Blood Transfusion
- Chemotherapy-Active
- Diabetes Mellitus
- Dizziness / Fainting
- Eaton Lambert Disease
- Epilepsy
- Eczema
- Hay Fever
- Heart Disease
- Hepatitis
- High Blood Pressure
- Infection-Active
- Kidney Disease
- Liver Disease
- Lupus
- Melanoma
- Melasma
- Mental Disorder
- Myasthenia Gravis
- Myopathy
- Nervous Disorder
- Neuromuscular Disease
- Psoriasis
- Radiation Treatment
- Respiratory Problems
- Sarcoidosis
- Sexually Transmitted Disease
- Skin Conditions
- Sinus Problems
- Stomach Problems
- Stroke
- Thyroid Disease
- Tuberculosis
- Ulcers

Are you allergic to any medications?

Medication allergy _____

Cosmetic allergy _____ Latex allergy _____

Have you ever, or do you currently use:

Retin A, Renova, any Retinoic acid product Yes No When: _____

Accutane Yes No When: _____

Prescription Acne Medication Yes No When: _____

Birth Control Pills / Patch / Hormones Yes No When: _____

Steroids Yes No When: _____

Are you pregnant or lactating (Due date -) Yes No When: _____

Do you form keloids (thick scars) Yes No When: _____

Have you ever had DermaDeep or DermaLive Yes No When: _____

Previous Cosmetic Treatments:

Chemical Peels Yes No Date: _____

Botox Yes No Date: _____

Restylane / Juvederm Yes No Date: _____

Dermal Fillers Yes No Date: _____

Collagen Yes No Date: _____

Tattoo / Permanent Makeup Yes No Date: _____

Waxing Yes No Date: _____

Facial Surgery Yes No Date: _____

Laser Surgery Yes No Date: _____

Microdermabrasion Yes No Date: _____

IPL Photofacial Yes No Date: _____

Laser Hair Reduction Yes No Date: _____

Have you ever had a cold sore or fever blister? Yes No

List all medications / supplements you currently take:

1. _____

2. _____

3. _____

4. _____

5. _____

6. _____

Plan: _____

Consultant: _____