Medical History Form

Patient Name: _____ **Date:** _____

Birthday: _____ **Gender:** _____ **Phone:** _____

E-mail: _____ **Occupation:** _____

Address: _____ **City, St, Zip:** _____

Emergency Contact: _____ **Phone:** _____

How did you hear about us: (circle one) Online search Referral Sign

Billboard Radio Print TV E-mail FB Instagram YouTube

Other: _____ Referred By: _____

Services that interest you…	Concerns you may have…	Surgical areas of interest…
☐ BOTOX® or Toxin	☐ Wrinkles or Laxity	☐ Breast Augmentation
☐ Injectable Fillers	☐ Volume Loss and Aging	☐ Facelift
☐ Liposuction	☐ Unwanted Body Fat	☐ Necklift
☐ Non-Surgical Face/Neck Firming	☐ Neck Laxity	☐ Stress Urinary Incontinence
☐ Non-Surgical Body Skin Firming	☐ Skin Creepiness and Tone	☐ Labiaplasty
☐ Non-Surgical Body Contouring	☐ Cellulite and Fat Reduction	☐ Liposuction
☐ Laser Resurfacing	☐ Resurfacing and Anti-Aging	☐ Tummy Tuck
☐ IPL	☐ Pigmentation Sun Damage	☐ Mommy Makeover
☐ Laser Hair Removal	☐ Permanent Hair Removal	☐ Breast Lift/Reduction
☐ Feminine Health	☐ Vaginal Discomfort/Appearance	☐ Brazilian Buttlift
☐ Microneedling Treatment	☐ Facial Rejuvenation	☐ Male Breast Reduction
☐ Medical Grade Skin Care	☐ Preventative Anti-aging	☐ Rhinoplasty
☐ Hair Transplantation	☐ Hair Loss/Recession	☐ Arm Lift (excess skin or fat)
☐ Kybella (Fat Reduction)	☐ Double Chin	☐ Scar Revision
☐ Latisse (eyelash enhancer)	☐ Short Thin Lashes	☐ Fat Transfer

Other Concerns:		

Is your general health good? ___Yes ___No

Date of last physical _____ Name of Family Physician _____

Present/Past Medical History: Have you ever had any of the following (please circle):

Asthma	Arthritis	Anemia	Autoimmune disorder
Blood disorder	Chest Pain	Chronic diarrhea	Clotting disorder
Colon problems	Diabetes	Depression	Easily Bruise
Excessive scarring	Excessive bleeding	Heart Attack	Heart valve disease
Heart valve replacement	Heart Failure	High blood pressure	Hepatitis
HIV	Irregular heart beat	Intestinal problems	Keloids
Kidney disease	Liver disease	Lung disease	Multiple Sclerosis
Muscular Dystrophy	HPV	Herpes	Migraines
Rheumatic fever	Shortness of breath	Seizures	Stroke
Stomach problems	Thyroid disorder	Cancer	Currently Pregnant

Please list type _____

List all surgeries or hospitalizations with in the last 5 years, with dates:

_____

_____

Have you ever had any cosmetic procedures in the past? If so what types?

_____

_____

To the best of my knowledge, the information provided above is true and accurate.

Patient Name: _____

Patient Signature: _____ Date: _____

Provider Signature: _____ Date: _____