Health History Short Summary

Name:

Age:

Date of Birth:

Blood Type:

Address (City, State, Zip)

Email:

Preferred method of contact
☐ Email ☐ Mail

Home Phone:

Work Phone:

Cell Phone:

Occupation:

Is occupation:
☐ Full Time ☐ Part Time

Employer:

Insurance Company:

Policy Number:

SS#:

Insurance Company Address (City, State, Zip):

Emergency Contact:

Emergency Contact Relationship:

Emergency Contact Phone:

Last physician or health practitioner seen:

When?

Do you currently have a primary care physician
☐ Yes. If yes, who? ☐ No

When was your last blood testing done?

What kind?

Who referred you to the office?

Your Current Aesthetic Desires

What is your MAIN reason for coming in?

If you have a specific aesthetic condition, please describe in detail

What aesthetic procedures have you tried before?

YOUR HEALTH HISTORY

Previous surgeries and hospitalizations, including dates:

Medical conditions that you have been diagnosed with:

Do you have any allergies to any drugs, herbs, foods, or other? Including benzocaine, lidocaine, tetracaine, numbing
cremes

- ☐ Yes. If yes, what?
- ☐ No

Are you currently lactating, breast feeding, pregnant?

- ☐ Yes
- ☐ No

Do you have a history of bells palsy, shingles, herpes, or uncontrolled diabetes, solar keratosis, current skin cancer

- ☐ Yes
- ☐ No

Medications (Please give full name, dosage, how long you have been taking the medication and the purpose of taking the medication):

Are you currently on these medications or treatment: Captropril, Immunosuppresants, Chemotherapy, Radiotherapy or high dose corticosteroids

- ☐ Yes
- ☐ No

Please select if you currently use any of the following:

- ☐ Alcohol
- ☐ Tobacco
- ☐ Hormones
- ☐ Coffee
- ☐ Cortisone
- ☐ Laxatives
- ☐ Sedatives
- ☐ Antacids

Thank you for completing this intake. We look forward to meeting you soon.