



ALOOF AESTHETICS PATIENT MEDICAL HISTORY

1. DEMOGRAPHICS

Today's Date: _____

Name: _____ Date of Birth: _____

Address: _____ City: _____ State: _____ Zip: _____

Email: _____ Phone: ^{Home} _____ ^{Cell} _____ ^{Work} _____ Other #: ^{Home} _____ ^{Cell} _____ ^{Work} _____

Preferred Contact: ^{Home} _____ ^{Cell} _____ ^{Work} _____ Is it important to be discreet? (circle) YES NO Sex: MALE FEMALE Martial Status: _____

Emergency Contact: _____ Phone #: _____ Relationship: _____

How did you hear about us? _____ Describe the nature of your visit: _____

2. MEDICAL HISTORY

Primary Care Physician: _____ Address: _____ Phone # _____

Do you have, or have you experienced any of the following? (Please Check Box)

<u>YES</u>	<u>NO</u>	<u>YES</u>	<u>NO</u>	<u>YES</u>	<u>NO</u>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Please describe those answered "YES": _____

Please indicate any other medical issues not listed: _____

3. MEDICATIONS, DOSAGE, AND FREQUENCY (Please list **ALL** Meds): _____

Please list **ALL** Vitamins, herbs, supplements or holistic treatments: _____

★ Have you been on Accutane in the past 6 months? Yes No Do you have problems getting numb at the Dentist? Yes No

4. FAMILY HISTORY

<u>YES</u>	<u>NO</u>	<u>YES</u>	<u>NO</u>	<u>YES</u>	<u>NO</u>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

5. ALLERGIES

<u>YES</u>	<u>NO</u>	<u>YES</u>	<u>NO</u>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Allergy: _____	Reaction: _____	Allergy: _____	Reaction: _____
Allergy: _____	Reaction: _____	Allergy: _____	Reaction: _____

6. SURGICAL HISTORY- List all Procedures/Surgeries and Dates

Surgery: _____ Date: _____ Surgery: _____ Date: _____

Surgery: _____ Date: _____ Surgery: _____ Date: _____

★ Any history of complications or bad result? **Yes** **No** If yes, please explain: _____

7. ANESTHESIA HISTORY-List history of anesthesia, complications, or reactions. Include local, general, spinal or epidural

8. WOMEN PATIENTS ONLY:

Number of pregnancies: _____ Number of Children _____ Did you breastfed? _____ If yes, how long _____

Do you have a menstrual cycle? _____ If no, indicate why? _____ If yes, date of last menstrual cycle _____

9. SOCIAL HISTORY

YES NO

- Tobacco, if yes Amount _____ # of years _____
- Alcohol, if yes Amount _____ # of years _____
- Recreational drugs, if yes Type _____
Amount _____ # of years _____

YES NO

- Caffeine, if yes Amount _____
- Daily exercise, if yes Amount _____

10. SKIN BACKGROUND

- 1) Have you had prolonged sun exposure in the past 3 days? **Yes** **No** If so, are you currently sunburned? _____
- 2) Do you use tanning beds? **Yes** **No**
- 3) Are you using chemical tanning solutions/creams? **Yes** **No**
- 4) Do you use sunscreen on a regular basis? **Yes** **No**
- 5) Acne? **Yes** **No** If yes, how frequent? **Frequent** **Occasional** **Rarely**
- 6) Do you experience cystic breakouts? **Yes** **No** Do you have scarring as a result **Yes** **No**
- 7) Do you use: Retin-A **Yes** **No** Glycolic **Yes** **No** Lactic Acid **Yes** **No** Hydroquinone **Yes** **No**
- 8) Current Skin Care Regime & Products Used: _____
- 9) **Skin Type (circle)** Caucasian Hispanic Mediterranean African American American Indian Asian Other: _____
- 10) Have you had BOTOX™, DYSPORT™, XEOMIN™, OR Dermal-filler injections in the past 6 months? **Yes** **No**
a.) If yes, please indicate approximate dates _____

11. CHECK OTHER SERVICES OF INTEREST:

- | | | |
|--|---|--|
| <input type="checkbox"/> Liposuction/Vaser Lipo/Lipo 360° | <input type="checkbox"/> Back Lift | <input type="checkbox"/> Non-Ablative LaserFacial (<i>Facial rejuvenation, Acne, Rosacea, Redness, Fine Lines, & Wrinkles</i>) |
| <input type="checkbox"/> Tummy Tuck/Abdominoplasty | <input type="checkbox"/> Hormone Replacement | <input type="checkbox"/> BOTOX™, DYSPORT™, or XEOMIN™ |
| <input type="checkbox"/> Brachioplasty (<i>Arm Lift</i>) | <input type="checkbox"/> Laser Hair Removal | <input type="checkbox"/> Facial Fillers (<i>lips, facial lines & wrinkles</i>) |
| <input type="checkbox"/> Breast Augmentation (<i>Implants</i>) | <input type="checkbox"/> Laser Vein Removal | <input type="checkbox"/> Laser Resurfacing (<i>facial Lines, wrinkles, acne scars, & facial rejuvenation</i>) |
| <input type="checkbox"/> BBL (Brazilian Butt Lift) | <input type="checkbox"/> Sclerotherapy | <input type="checkbox"/> Microdermabrasion, Chemical Peels |
| <input type="checkbox"/> Fat Transfer | <input type="checkbox"/> Pigmented Lesion Removal (<i>unwanted brown spots</i>) | <input type="checkbox"/> Laser Acne Treatments |
| <input type="checkbox"/> Thigh Lift | <input type="checkbox"/> Mole Removal | <input type="checkbox"/> Anti-Aging Skin Care & Makeup |
| <input type="checkbox"/> Mini Face Lift | <input type="checkbox"/> Ear Lobe Repair | |
| <input type="checkbox"/> Brow Lift | | |

12. LIVING WILL:

★ Do you have a living will? **Yes** **No** If no, would you like information regarding one? **Yes** **No**

13. DNR:

★ Are you a DNR (Do Not Resuscitate) patient? **Yes** **No**

I certify that the above medical history is accurate and correct to the best of my knowledge:

Print Name: _____ Signature: _____ Date: _____

Relationship to patient if minor: _____