



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

Height: _____ Current Weight: _____ Heaviest Weight: _____

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"/> Heart attack	<input type="checkbox"/>	<input type="checkbox"/> High Cholesterol	<input type="checkbox"/>	<input type="checkbox"/> Pregnant or Lactating
<input type="checkbox"/>	<input type="checkbox"/> Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/> Dizziness or fainting	<input type="checkbox"/>	<input type="checkbox"/> Thyroid problems
<input type="checkbox"/>	<input type="checkbox"/> Heart murmur	<input type="checkbox"/>	<input type="checkbox"/> Epilepsy or seizures	<input type="checkbox"/>	<input type="checkbox"/> Pneumonia
<input type="checkbox"/>	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/> Stroke	<input type="checkbox"/>	<input type="checkbox"/> Respiratory Disease
<input type="checkbox"/>	<input type="checkbox"/> Heart Condition	<input type="checkbox"/>	<input type="checkbox"/> Immune Disorders	<input type="checkbox"/>	<input type="checkbox"/> Asthma
<input type="checkbox"/>	<input type="checkbox"/> Varicose veins	<input type="checkbox"/>	<input type="checkbox"/> Anxiety	<input type="checkbox"/>	<input type="checkbox"/> Disabilities
<input type="checkbox"/>	<input type="checkbox"/> Arthritis or Rheumatoid	<input type="checkbox"/>	<input type="checkbox"/> Anemia	<input type="checkbox"/>	<input type="checkbox"/> Gall bladder problems
<input type="checkbox"/>	<input type="checkbox"/> Diabetes	<input type="checkbox"/>	<input type="checkbox"/> Hepatitis, liver, or kidney disease	<input type="checkbox"/>	<input type="checkbox"/> HIV
<input type="checkbox"/>	<input type="checkbox"/> Contact Lenses	<input type="checkbox"/>	<input type="checkbox"/> Dental appliances	<input type="checkbox"/>	<input type="checkbox"/> Sleep apnea or snoring
<input type="checkbox"/>	<input type="checkbox"/> Hearing Aid	<input type="checkbox"/>	<input type="checkbox"/> Blood transfusion	<input type="checkbox"/>	<input type="checkbox"/> Acid reflux
<input type="checkbox"/>	<input type="checkbox"/> Bleeding disorder	<input type="checkbox"/>	<input type="checkbox"/> Blood Clot	<input type="checkbox"/>	<input type="checkbox"/> Cold Sore
				<input type="checkbox"/>	<input type="checkbox"/> Cancer

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"/> Abnormal bleeding	<input type="checkbox"/>	<input type="checkbox"/> Diabetes	<input type="checkbox"/>	<input type="checkbox"/> Liver Disease
<input type="checkbox"/>	<input type="checkbox"/> Cancer	<input type="checkbox"/>	<input type="checkbox"/> Anesthetic problems	<input type="checkbox"/>	<input type="checkbox"/> Malignant Hyperthermia
<input type="checkbox"/>	<input type="checkbox"/> Heart Disease or Stroke	<input type="checkbox"/>	<input type="checkbox"/> Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/> Sudden Death

5. ALLERGIES

<u>YES</u>	<u>NO</u>	<u>YES</u>	<u>NO</u>
<input type="checkbox"/>	<input type="checkbox"/> Drug Allergies, if yes indicate below	<input type="checkbox"/>	<input type="checkbox"/> Latex Allergy, if yes indicate below
<input type="checkbox"/>	<input type="checkbox"/> Food Allergies, if yes indicate below	<input type="checkbox"/>	<input type="checkbox"/> Tape Allergy, if yes indicate below
		<input type="checkbox"/>	<input type="checkbox"/> other: _____
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:

____ Liposuction/Vaser Lipo/Lipo 360°

____ Tummy Tuck/Abdominoplasty

____ Brachioplasty (Arm Lift)

____ Breast Augmentation (Implants)

____ BBL (Brazilian Butt Lift)

____ Fat Transfer

____ Thigh Lift

____ Mini Face Lift

____ Brow Lift

____ Back Lift

____ Hormone Replacement

____ Laser Hair Removal

____ Laser Vein Removal

____ Sclerotherapy

____ Pigmented Lesion Removal

(unwanted brown spots)

____ Mole Removal

____ Ear Lobe Repair

____ Non-Ablative LaserFacial (Facial rejuvenation, Acne, Rosacea, Redness, Fine Lines, & Wrinkles)

____ BOTOX™, DYSPORT™, or XEOMIN™

____ Facial Fillers (lips, facial lines & wrinkles)

____ Laser Resurfacing (facial Lines, wrinkles, acne scars, & facial rejuvenation)

____ Microdermabrasion, Chemical Peels

____ Laser Acne Treatments

____ Anti-Aging Skin Care & Makeup

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: _____