ALOUF 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)

YES	NO		YES	NO		YES	NO	
☐	☐	Heart attack	☐	☐	High Cholesterol	☐	☐	Pregnant or Lactating
☐	☐	Rheumatic Fever	☐	☐	Dizziness or fainting	☐	☐	Thyroid problems
☐	☐	Heart murmur	☐	☐	Epilepsy or seizures	☐	☐	Pneumonia
☐	☐	High Blood Pressure	☐	☐	Stroke	☐	☐	Respiratory Disease
☐	☐	Heart Condition	☐	☐	Immune Disorders	☐	☐	Asthma
☐	☐	Varicose veins	☐	☐	Anxiety	☐	☐	Disabilities
☐	☐	Arthritis or Rheumatoid	☐	☐	Anemia	☐	☐	Gall bladder problems
☐	☐	Diabetes	☐	☐	Hepatitis, liver, or kidney disease	☐	☐	HIV
☐	☐	Contact Lenses	☐	☐	Dental appliances	☐	☐	Sleep apnea or snoring
☐	☐	Hearing Aid	☐	☐	Blood transfusion	☐	☐	Acid reflux
☐	☐	Bleeding disorder	☐	☐	Blood Clot	☐	☐	Cold Sore
						☐	☐	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

YES	NO		YES	NO		YES	NO	
☐	☐	Abnormal bleeding	☐	☐	Diabetes	☐	☐	Liver Disease
☐	☐	Cancer	☐	☐	Anesthetic problems	☐	☐	Malignant Hyperthermia
☐	☐	Heart Disease or Stroke	☐	☐	Kidney Disease	☐	☐	Sudden Death

5. ALLERGIES

YES	NO		YES	NO	
☐	☐	Drug Allergies, if yes indicate below	☐	☐	Latex Allergy, if yes indicate below
☐	☐	Food Allergies, if yes indicate below	☐	☐	Tape Allergy, if yes indicate below
			☐	☐	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		YES	NO	
☐	☐	Tobacco, if yes Amount_____# of years_____	☐	☐	Caffeine, if yes Amount_____
☐	☐	Alcohol, if yes Amount_____# of years_____	☐	☐	Daily exercise, if yes Amount_____
☐	☐	Recreational drugs, if yes Type_____ Amount_____# of years_____			

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:_____