

**Medical History Questionnaire**

First Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

MI\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone Number\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Last Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**General Information**

1. Are you currently under the care of a Physician?

Yes \_\_\_\_\_ No\_\_\_\_\_

If yes, what for?

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1. Are you currently under the care of a Dermatologist?

Yes \_\_\_\_\_ No\_\_\_\_\_

If yes, what for?

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1. Do you have a history of erythema abigne, which is a persistent skin rash produced by prolonged or repeated exposure to moderately intense heat or infrared irritation?

Yes \_\_\_\_\_ No\_\_\_\_\_

1. Do you have any of the following medical conditions? (check all that apply)

Cancer\_\_\_\_\_ Diabetes\_\_\_\_\_ High Blood Pressure\_\_\_\_\_

Herpes\_\_\_\_\_ Frequent Cold Sores\_\_\_\_\_ HIV/AIDS\_\_\_\_\_

Keloid Scarring\_\_\_\_\_ Skin Disease/Lesions\_\_\_\_\_ Seizure Disorder\_\_\_\_\_

Hepatitis\_\_\_\_\_ Hormone Imbalance\_\_\_\_\_ Thyroid Imbalance\_\_\_\_\_

Blood Clotting Abnormalities\_\_\_\_\_ Any active infection\_\_\_\_\_

1. Do you have any other health problems or medical conditions? Please list:

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1. Have you ever had an allergic reaction to any of the following? Please check all that apply.

Food\_\_\_\_\_\_ Latex\_\_\_\_\_\_ Aspirin\_\_\_\_\_\_

Hydrocortisone\_\_\_\_\_\_ Hydroquinone\_\_\_\_\_\_ Lidocaine\_\_\_\_\_\_

Others\_\_\_\_\_\_

**Medication**

1. What oral/topical medication are you currently taking?

Birth Control Pills\_\_\_\_ Hormones\_\_\_\_

Others (Please specify) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Are you on any mood-altering or anti-depression medication?

Yes \_\_\_\_\_ No\_\_\_\_\_

**Cosmetic History**

1. Have you had a cosmetic procedure in the past?

Yes \_\_\_\_\_ No\_\_\_\_\_

1. (a) Have you had any dermal filler?

Yes \_\_\_\_\_ No\_\_\_\_\_

(b) Have you ever had Neuromodulator procedure?

Yes \_\_\_\_\_ No\_\_\_\_\_

1. Have you had any allergic reaction or complications from a cosmetic procedure?

Yes \_\_\_\_\_ No\_\_\_\_\_\_\_ NA\_\_\_\_\_\_\_

1. If Yes, please describe \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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1. Have you ever had local anaesthesia with lidocaine?

Yes \_\_\_\_\_ No\_\_\_\_\_

**For Female Clients**

1. Are you pregnant or planning for pregnancy? Yes\_\_\_\_ No\_\_\_\_
2. Are you breastfeeding? Yes\_\_\_\_ No\_\_\_\_
3. Are you using contraception? Yes\_\_\_\_ No\_\_\_\_

Which of the following best describe your skin type?

Always Burn, Never Tan\_\_\_

Always Burn, Sometimes Tan\_\_\_

Sometimes Burn, Always Tan\_\_\_

Rarely Burn, Always Tan\_\_\_

Brown, moderately pigmented skin\_\_\_

Heavily pigmented, very dark skin\_\_\_

Client Signature Date