Patient Name: _____

Date: _____

What services are scheduled today?

Are you allergic to any medications?

☐ Yes ☐ No

If yes, which medication? _____

Have you taken either of the following?

☐ Accutane ☐Gold Therapy

If yes for either above, how long ago? _____

Current Medications

Are you or have you taken antibiotics within the last 2 weeks?

☐ Yes ☐ No

If yes, which antibiotic and when? _____

Are you currently taking any Iron Supplements?

☐ Yes ☐ No

If yes, which supplement? _____

Are you using Retin-A?

☐ Yes ☐ No

If yes, when was the last application? _____

Are you using any topical medications containing Retinol?

☐ Yes ☐ No

If yes, which medication and when? _____

Are you using Hydroquinone Cream?

☐ Yes ☐ No

If yes, when was the last application? _____

Are you on any Blood Thinners?

☐ Yes ☐ No

☐ Aspirin ☐ NSAIDS

☐ Plavix ☐ Other _____

☐ Coumadin

Are you allergic to any of the following?

☐ Lidocaine ☐ Penicillin

☐ Benzocaine ☐ Tetracycline

☐ Tetracaine ☐ Latex

☐ Sulfa ☐ Other_____

FEMALES: Are you currently pregnant?

☐ Yes ☐ No

FEMALES: Are you currently breastfeeding?

☐ Yes ☐ No

Do you have a history of Herpes Type 1 Infections?

☐ Yes ☐ No

If yes, when was the last breakout? _____

Do you have any open skin lesions?

☐ Yes ☐ No

Do you have currently have any skin infections?

☐ Yes ☐ No

Do you have a tendency to Keloid Scarring?

☐ Yes ☐ No

What is your Fitzpatrick Skin Type?

Sun burn:	Always	Usually	Sometimes	Rarely	Never
	I	II	III	IV	V

What is your hair color?

☐ Black ☐ Grey

☐ Brown ☐ Blonde

☐ Red ☐ Salt/Pepper

Please list all current and active medical issues or conditions

Do you smoke?

☐ Yes ☐ No

If yes, how often? _____

Do you consume alcohol?

☐ Yes ☐ No

If yes, how often? _____

Have you ever had BOTOX before?

☐ Yes ☐ No

If yes, did you have any adverse side effects?

☐ Yes ☐ No

Do you have Amyotrophic Lateral Sclerosis (ALS)?

☐ Yes ☐ No

Myasthenia gravis?

☐ Yes ☐ No

Lambert-Eaton Disorder?

☐ Yes ☐ No

Bells palsy?

☐ Yes ☐ No

Past dermal filler

☐ Yes ☐ No

If yes, which filler and when? _____

Did you have any adverse side effects?

☐ Yes ☐ No

Have you ever had Facial Implants?

☐ Yes ☐ No

Do you have a Pacemaker or Implantable Defibrillator?

☐ Yes ☐ No

Glaucoma

☐ Yes ☐ No

Lens implants

☐ Yes ☐ No

Macular degeneration

☐ Yes ☐ No

Uveitis?

☐ Yes ☐ N