

Stefanie Magnant R.N. Aesthetics

MEDICAL HISTORY FORM

Date ___/___/___ Home # _____ Cell # _____

Name _____ DOB ___/___/___ Age _____

Address: _____ City _____ State ___ Zip _____

Email: _____

Employer: _____ Occupation _____

How were you referred? _____

Medical History

Have you ever been treated for any of the following conditions? Circle all that apply.

Allergy to botulinum toxin	Swallowing Problems	Shingles
Acne	Alcoholism	Skin Pigmentation
Blood Disorder	Drug Abuse	Myasthenia Gravis
Burns/Skin Grafts	HIV	Anxiety
Steroid/Hormone Therapy	Melanoma	Muscle Weakness
Cancer (Radiation/Chemo)	Keloid Formation	Bleeding Problems
Diabetes	Kidney Disease	ALS
Herpes (Cold Sores)	High Blood Pressure	Lambert Eaton
Depression Syndrome		

If you checked any of the above conditions, please explain:

ALLERGIES TO MEDICATIONS: _____

Are you being treated for any other chronic medical condition? _____

Are you currently taking any medications? (Including Aspirin, Ibuprophen, Advil, etc.?) _____

Have you ever been treated with Botox or other neurotoxin? _____

Have you ever been treated with fillers? _____

Do you have facial implants? _____

Do you have any skin sensitivity? _____

Have you had surgery performed in the last 6 months? _____

Are you currently pregnant or trying to conceive? _____

Are you currently breastfeeding? _____

Please sign below to indicate all the information on this form is accurate and complete.

Patient Signature

Date

R.N. Signature

Date

NOTES

MEDICAL HISTORY

Name _____

Address: _____

Home Phone _____ Cell Phone _____

Age _____ Referred by _____

Have you ever suffered from the following?

Diabetes _____ Yes _____ No

Bleeding Disorder _____ Yes _____ No

Are you pregnant? _____ Yes _____ No

What medications are you taking (including aspirin)? _____

What is your daily consumption of alcohol? _____

Allergies: _____

Are you taking any herbal preparations? (Such as St. John's Wort) ___ Yes ___ No

If yes, list _____

Do you wear contact lenses? _____ Yes _____ No

Mark your skin type (when exposed to the sun without protection for about 1hour)

- I Always burns, never tans
- II Always burns, sometimes tans
- III Sometimes burns, sometimes tans
- IV Always tans
- V Hispanic, Asian, Mediteranean, Middle Eastern
- VI Black

When where you last exposed to the sun (including tanning booths)? _____

Do you use chemical sun tanning lotions? _____ Yes _____ No

Are you planning a holiday in the sun? _____ Yes _____ No

Reason for visit (area to be treated) _____

Have you ever had a treatment for the removal of tattoos before ___ Yes ___ No

Have you ever had treatments for pigmented lesions? _____ Yes _____ No

Prior treatment (if any) _____