Medical History Form

Patient Information

Full Name: _____

Date of Birth: _____

Phone Number: _____

Email Address: _____

Emergency Contact Name & Phone: _____

1. General Health Information

Please answer the following questions regarding your general health.

• Do you have any known allergies? (e.g., medications, food, latex, etc.)

☐ Yes ☐ No

If yes, please list: _____

• Are you currently taking any prescription medications?

☐ Yes ☐ No

If yes, please list all medications (including dosage): _____

• Are you currently taking any over-the-counter supplements or vitamins?

☐ Yes ☐ No

If yes, please list: _____

• Do you have any current or past medical conditions? (Please check all that apply)

☐ Diabetes

☐ High Blood Pressure

☐ Heart Disease

☐ Stroke

☐ Seizures

☐ Asthma or Respiratory Conditions

☐ Autoimmune Diseases

☐ Hepatitis

☐ HIV/AIDS

☐ Cancer

☐ Other (please specify): _____

• Are you pregnant or breastfeeding?

☐ Yes ☐ No

• Have you had any previous surgeries or hospitalizations?

☐ Yes ☐ No

If yes, please provide details: _____

2. Aesthetic Treatment History

• Have you had any previous aesthetic treatments? (e.g., Botox, dermal fillers, chemical peels, laser treatments, etc.)

☐ Yes ☐ No

If yes, please list the treatments and the dates: _____

• Have you experienced any adverse reactions to any cosmetic treatments or products in the past?

☐ Yes ☐ No

If yes, please describe:_____

• Do you have any history of scarring or keloid formation?

☐ Yes ☐ No

• Have you had any recent skin infections, open wounds, or cold sores around the treatment area?

☐ Yes ☐ No

• Do you have a history of or are you currently experiencing any of the following?

☐ Acne

☐ Rosacea

☐ Eczema or Psoriasis

☐ Sensitive skin

☐ Hyperpigmentation

☐ Hypopigmentation

☐ Sunburns or Tanning Bed use within the past 2 weeks

3. Botox & Dermal Filler Specific Questions

• Are you considering Botox treatment?

☐ Yes ☐ No

If yes, do you have any of the following?

☐ Neuromuscular disease (e.g., myasthenia gravis)

☐ Difficulty swallowing or breathing

☐ History of Botox allergy or adverse reactions

• Are you considering dermal fillers?

☐ Yes ☐ No

If yes, do you have any of the following?

☐ History of cold sores

☐ History of allergic reactions to lidocaine

☐ Use of blood thinners or anticoagulants

4. Skin and Sun Exposure

• Do you frequently expose your skin to the sun, tanning beds, or UV ray?

☐ Yes ☐ No

• Do you use sunscreen regularly?

☐ Yes ☐ No

• Do you have a history of excessive sunburns or sun damage?

☐ Yes ☐ No

5. Additional Information

• Is there anything else you would like us to know about your medical history or skin concerns?

• Are you currently taking antibiotics, or have taken antibiotics in the past 2 weeks?

☐ Yes ☐ No

If yes, please specify why and start/stop date :_____

Patient Consent

I acknowledge that the information provided above is accurate and complete to the best of my knowledge. I understand that withholding information or providing false information could lead to complications or adverse effects during or after my aesthetic treatments. I agree to inform the Medspa immediately if any changes occur in my health or medications.

Signature of Patient: _____ Date: _____

Signature of Provider (or Representative): _____ Date:_____