COMPREHENSIVE PATIENT MEDICAL AND COSMETIC HISTORY FORM

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Patient Name:

MEDICAL HISTORY:

1. Are you taking ANY kind of medication now? ☐ No ☐ Yes
(This includes prescription, over-the-counter or herbal medications)

Medication Name	Dosage	Problem being treated	Doctor's Name

2. Are you allergic to any medications? ☐ No ☐ Yes If yes, please list below.

Name of Medication	Type of Reaction

3. Do you have any medical problems? If so, please list:

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4. List any Prior surgeries: (non-cosmetic)

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AESTHETIC AND SKIN HISTORY:

1. Please check any of the following aesthetic procedures you have had in the past:

☐ Facelift ☐ Brow lift ☐ Rhinoplasty ☐ Blepharoplasty (Eyelids)

☐ Laser Treatment ☐ Thermage ☐ IPL ☐ Fillers (Juvederm, Perlane)

☐ Botox ☐ Hair removal ☐ Chemical Peels ☐ Microdermabrasion

2. Please check any of the following treatments you have done or are currently doing

Retin-A (Renova, topical Vitamin A) ☐ In the past ☐ Currently

Accutane ☐ In the past ☐ Currently

Topical Alpha Hydroxy or Glycolic Acid ☐ In the past ☐ Currently

If yes, please answer the following: ☐ Prescription ☐ Over the Counter

Brand: _____