**PATIENT HISTORY**

Today's date: _____
Name: _____
Address _____
City _____ State_____ Zip _____
Preferred Contact Cell Number: _____
May we leave a detailed message at this number? Yes No
Email Address: _____

Personal Information
Date of Birth: _____ Age_____ Gender: Female
Male Marital Status_____ Occupation
_____

What Services Do You Want To Learn About?
_____Minimize Wrinkles & Skin Rejuvenation Lines
_____Longer Natural Eye Lashes
_____Facial Redness
_____Age Spots / Melasma / Pigmentation Over All Skin Care
_____Medical weight Loss
_____Laser Hair Removal
_____Tattoo Removal
_____Minimize Acne or Break-Outs Acne Scars
_____Relief Fatigue and increase concertation

How Did You Find Us? (Mark all that apply)
_____Internet
_____Facebook
_____Living Social / Groupon PrideGuide
_____Radio
_____Television
_____Walking By
_____A Friend Told Me –

Previous Cosmetic or invasive or non-invoices fat removal or weight loss Treatments:
Botox ® Date: _____,
Dysport Date: _____,
Dermal Fillers: Date: _____,
Cosmetic Surgery: Date: _____
Chemical Peel: Date: _____,
Microdermabrasion Date: _____
Laser Treatments: Date: _____.
PRP Microneedling (Vampire Facial): Date_____
PRP Facelift (Vampire Facelift): Date: _____
Laser Hair removal Date:_____, SIte/s:_____
CoolSculpting Date:_____, Site/s:_____

Patient's Initial _____

| **Medical HISTORY (*please circle all that apply*)** |
|---|
| Do you have a history of **herpes** I or II in the area to be treated? Yes No |
| **Cryoglobulinemia** or paroxysmal cold hemoglobinuria? Yes No |
| Have you taken **Accutane** or anticoagulants in the last 6 months? Yes No |
| Have you taken **Anticoagulants** in the last 6 months? Yes No |
| (For women) Are you or could you be **Pregnant** or **Nursing** mother (Breastfeeding)? Yes No |
| Have you had any unprotected **sun exposure** in the last 4-6 weeks? Yes No |
| Have you used **tanning** creams or tanning beds in the last 4-6 weeks? Yes No |
| Have you **plugged** your hair or wax in the past 2 weeks? Yes No |
| Any history of **Folliculitis**? Yes No |
| Known sensitivity to cold such as **cold urticaria** or **Raynaud's disease**? Yes No |
| Impaired **peripheral circulation** in the area to be treated Yes / No |
| Impaired skin sensation? Yes No |
| Open or **infected** wounds? Y es No |
| Recent **surgery** or scar tissue in the area to be treated? Yes No |
| A hernia or history of **hernia** in the area to be treated? Yes No |
| Skin conditions such as **eczema**, **dermatitis**, or **rashes**? Yes No |
| Any active implanted devices such as **pacemakers** and **defibrillators**? Yes No |
| Have you had **darkening** of the skin or **lightening** of the skin? Yes No |
| Do you have a history of **keloid** or **hypertrophic** scarring? Yes No |
| Do you have a history of **inflammatory** dermatoses? Yes No |
| Do you have a history of **Melasma**? Yes No |
| Do you have a history of **scleroderma**? Yes No |
| Do you have a history of **collagen** vascular disease? Yes No |
| Do you have **immunosuppression**? Yes No |

Please circle any conditions you are suffering right now:

| **General** | **Head / Ears / Nose / Throat** | **Pulmonary** | **Metabolic** |
|---|---|---|---|
| Unplanned Weight Change<br>Fevers/Chills<br>Loss of Energy<br>Fatigue | Visual Problems Glasses / Contacts Cataracts<br>Hearing Problems<br>Sinus problem<br>Neck pain<br>Thyroid Problem | Cough<br>Wheezing<br>Shortness of Breath<br>Positive TB Test<br>Snoring<br>Headache<br>Asthma<br>Sleep Apnea | Diabetes<br>Hypertension<br>High Cholesterol |

| Cardiac | Gastrointestinal | Genitourinary | Psychological |
|---|---|---|---|
| Chest Pain with Exertion<br>Chest Pressure<br>Irregular Heart Beat<br>Palpitations<br>Congestive Heart Failure<br>Rheumatic Fever | Abdominal Pain<br>Trouble Swallowing<br>Nausea/Vomiting<br>Dark / Black Stool<br>Jaundiced<br>Diarrhea<br>Constipation<br>Bright Red Blood in Stool Hemorrhoids<br>Stomach Ulcers<br>Heartburn or Reflux | Blood in Urine Hesitancy<br>Kidney Stones<br>Frequent Urination<br>Prostate Problems<br>Discomfort-Urination | Depression<br>Anxiety<br>Alcoholism<br>Street drug use<br>Insomnia |

| Hematological | Neurological | Musculoskeletal | Gynecologic |
|---|---|---|---|
| Abnormal Bleeding Easy Bruising<br>Blood Clots in Legs/Lungs<br>HIV, AIDS<br>Nose Bleeds<br>Hepatitis B Hepatitis C | Headaches<br>Dizziness<br>Passing Out<br>Seizure / Epilepsy<br>Stroke<br>Bell's Palsy<br>Trigeminal Neuralgia | Swelling in Extremities<br>Leg Ulcers<br>Varicose Veins | Breast Pain<br>Breast Discharge<br>Menopause<br><br>**Skin**<br>Rash<br>Herpes (Coldsore)<br>Shingles |

List **ALL** prescriptions and over-the-counter medications presently using:

_____
_____
_____
_____
_____
_____

List **ALL DRUG,** food, latex or other substances allergies:

_____
_____
_____

List **ALL** surgeries and dates:

_____
_____
_____
_____

**Family Medical History** (please check all that apply)

Heart Disease/Stroke Diabetes
High Cholesterol Obesity
High Blood Pressure Cancer
Other_____
_____