HEALTH HISTORY

HINGHAM MEDICAL AESTHETICS

Date:_____

Name:_____ DOB:_____ Age:_____

Gender: ☐ Male ☐ Female ☐ Other Marital status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced

Address:_____ City:_____ State:_____ Zip:_____

Home Phone:_____ Cell:_____ Work:_____

Emergency Contact:_____ Contact's Phone:_____

Email:_____

Employer:_____ Occupation:_____

Pharmacy:_____ Pharmacy Phone:_____

MEDICAL HISTORY Have you ever been diagnosed or treated for any or the following conditions? No / Yes (Please check all that apply.)

☐ Acne	☐ Heart disease / cardiac arrest	☐ Myasthenia Gravis
☐ Auto-immune disorder	☐ Herpes Simplex / cold sore	☐ Neurological problem
☐ Blood disorder - bleeding	☐ High blood pressure	☐ PCOS / ovarian cysts
☐ Blood disorder - clotting	☐ Hirsutism	☐ Psoriasis
☐ Burns / skin grafts	☐ HIV	☐ Psychiatric disorder
☐ BPH (males)	☐ Hormone imbalance	☐ Scarring issue / keloid scarring
☐ Cancer	☐ Hyperpigmentation	☐ Stroke
☐ Diabetes	☐ Kidney disease	☐ Thyroid disorder
☐ Dizziness / fainting	☐ Muscle weakness	☐ Vitiligo

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

_____

_____

Are you currently pregnant, trying to conceive or nursing?

Do you smoke? ☐ Never ☐ Occasionally ☐ Regularly ☐ Frequently

Do you drink alcohol? ☐ Never ☐ Occasionally ☐ Regularly ☐ Frequently

Sun Exposure history? ☐ Never ☐ Occasionally ☐ Regularly ☐ Frequently

ALLERGIES

Medications:

_____ Reaction:_____

Food:

_____ Reaction:_____

Latex:

_____ Reaction:_____

Skin Sensitivities:

_____ Reaction:_____

Have you ever experienced anaphylaxis? ☐ no ☐ yes

_____

MEDICATIONS

Please list your current medications: ☐ no ☐ yes

_____

Please list your current over the counter (OTC) medications or vitamins and / or supplements:

_____

Please list your current topical medications:

_____

Please list your current cosmetic / derrnatologic product usage:

Have you received Accutane therapy in the last 12 months? ☐ no ☐ yes _____

Have you ever been treated with a neurotoxin (Botox®, Dysport®, Xeomin®)? ☐ no ☐ yes _____

Have you ever been treated with dermal filler (Juvederm®, Restylane®, etc)? ☐ no ☐ yes _____

SURGERY OR HOSPITALIZATION

☐ Cosmetic:

_____

_____

☐ Therapeutic:

_____

_____

☐ Hospitalization (Please explain why and when):

_____

_____

Primary Care Physician:

_____

Name:_____ Address:_____

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

Signature:_____ Date:_____

Printed Name:_____ Date:_____

Witness signature:_____ Date:_____