Medical History

Name_____ Email _____
Address_____City_____ Zip _____
Phone _____ DOB_____ Age_____ Smoker Y/ N Who Referred You?_____
What would you like to discuss with Meredith today?_____

What skin care line are you currently using? _____
Do you use daily environmental protection (SPF)? Y / N If yes, what? _____ If not, why?_____
Rate the way you feel about the overall quality of your skin (1-10; 10 is best) _____
Your skin type is: Normal Dry/Dehydrated Oily Acne/Prone Rosacea Sensitive
Please note the areas you would like to discuss with Meredith:
_____ fine lines _____ deep wrinkles _____ sagging skin _____acne _____ red facial veins/rosacea _____ pigment/melasma
_____brighten complexion _____ facial hair _____ neck/double chin _____ Facial/Hand Volume replacement

Please List all the medications you are currently taking:_____
_____
List all vitamin supplements you are on:_____
List all Allergies:_____
Circle any of the following illnesses you have or have ever had in the past:

Neurological Disorders	Autoimmune Disease	Muscle Weakness/disease	Numbness
Disorder that is light-sensitive	Vision Problems	Severe allergies	Lidocaine allergy
Eye Disease	Cold Sores		

Have you received, or will you receive dental care (including cleanings) within two weeks of today? Y / N
Have you received or will you receive vaccinations within two weeks of today? Y / N
Have you been ill with an upper respiratory or sinus infection or been on antibiotics in the past two weeks? Y / N
Are you currently under the care of a physician for any chronic or short-term illness? Y / N
List any other medical conditions not listed above that you currently have or have had in the past:
_____
_____
Previous Hospitalizations/Operations: _____
Female: Are you pregnant, trying to get pregnant, or lactating (nursing)?_____

Have you had Plastic Surgery or other surgery to your face/neck areas? When?_____
Had Botox injections before? _____Last treatment?_____ What areas?_____ Happy with Treatment?_____
Ever had eyelid/eyebrow drooping after Botox? Explain_____
Have you been told you have 'sleep eyes' or 'bedroom eyes'? Explain_____
Do you show a lot of upper lid when eyes are open? Explain_____
Do your eyelids feel heavy when you don't get enough sleep?_____
Have you had any Dermal Filler procedures before? _____If yes, what?_____ when? _____

I understand the information on this form is essential to determine my medical and cosmetic needs and the provision of treatment. I understand that if any changes occur in my medical history/health I will report it to New Life Aesthetics as soon as possible. I have read and understand the above medical history questionnaire. I acknowledge that all answers have been recorded truthfully and will not hold any staff member responsible for any errors or omissions that I have made in the completions of this form.

Patient signature_____Date:_____