Aesthetic Medial History Form

First Name: _____ Last Name: _____ Age: _____

Address: _____ Apt/Unit: _____

City: _____ Zip Code: _____

Phone: _____ Email: _____

Pharmacy: _____ Pharmacy Address: _____

How did you find out about us? _____

If referred, who referred you? _____

Which body areas would you like treated? _____

Please answer each of the following questions:

Are you pregnant or breastfeeding? □ YES □ NO

Do you have a pacemaker or defibrillator? □ YES □ NO

Do you have any metal implants under the area being treated? □ YES □ NO

Do you have any open sores or lesions? □ YES □ NO

Do you have any allergies to medications, foods, latex, or other substances? □ YES □ NO
Please List: _____

Do you have any chronic skin conditions? □ YES □ NO
Please List: _____

Are you using topical products on your skin on a regular or daily basis? □ YES □ NO
Please List: _____

Have you had any cosmetic procedures in the past 6 months? □ YES □ NO
Please List: _____

Have you been treated with Botox/Dysport in the last month? □ YES □ NO
Please List: _____

Which skin type best describes your skin?

☐ **Type 1**	☐ **Type 2**	☐ **Type 3**	☐ **Type 4**	☐ **Type 5**	☐ **Type 6**
Always burns Never tans	*Burns easily Tans minimally*	*Burns moderately Tans to light brown*	*Burns minimally Tans to moderate brown*	*Rarely burns Tans to dark*	*Never burns Least sensitive*
Pale White Skin	White Skin	Light Brown Skin	Moderate Brown Skin	Dark Brown Skin	Brown-Black Skin