



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.)

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