Medical History Form- Prescott Medical Aesthetics

Name:_____Date: _____ Date of Birth:_____
Home Address:_____ City: _____ State: _____ Zip: _____
Phone number: _____Email Address:_____
Emergency contact name & phone #_____
Occupation:_____Work Phone:_____
List all Medication, Food, and Makeup ALLERGIES:_____
List all medications you are taking: Prescription and Homeopathic as well as Retin A, Glycolic Acid & Acutane, Aspirin, Ibuprofen, Vitamins and all other Over the Counter Meds:

_____
_____

Have you ever had a MRSA/staph Infection? ☐Y ☐ N If yes, was the infection acquired in a hospital? ☐Y☐ N
Do you take prophylactic premeds before having a procedure at the dentist ☐Y☐ N, If so, what?_____
What products do you use for skin care? _____
Do you have any of the following conditions? (Check Yes or No)
☐Yes ☐ No Cold Sores, when? _____ ☐Yes ☐ No Herpes Simplex Shingles, when? _____
☐Yes ☐ No Dry Eye- Use Drops? _____ ☐Yes ☐ No Corneal Abrasion, when? _____
☐Yes ☐ No Eye Surgery/ Injury, when? _____
☐Yes ☐ No Cataracts Visual Disturbances/ Glaucoma Wear Contacts Tumors/ Growths/ Cysts (Circle)
☐Yes ☐ No Abnormal Heart Condition _____
☐Yes ☐ No High/ Low Blood Pressure (Circle)
☐Yes ☐ No Circulatory Problems Fainting/Dizzy Spells (Circle)
☐Yes ☐ No Hemophilia Prolonged Bleeding why? _____
☐Yes ☐ No Hepatitis _____ ☐Yes ☐ No Allergic to Cow's Milk Protein ☐Yes ☐ No Diabetes?
☐Yes ☐ No Chemo/ Radiation (ever)? ☐Yes ☐ No Use Tobacco Products? ☐Yes ☐ No Cosmetic Surgeries? ☐Yes ☐ No Facial Cosmetic Surgery? ☐Yes ☐ No Using eye drops?
☐Yes ☐ No Pregnant, or Nursing?
☐Yes ☐ No Diagnosed with any peripheral motor neuropathic diseases that affect your muscles and nerves, such as: ALS, Lou Gehrig's Disease, Myasthenia Gravis or Lambert Eaton Syndrome.
☐Yes ☐ No Have you had any type of Laser, Photofacial, Botox, Dysport, Restylane, Radiesse, Sculptra, Hylaform, Perlane, Collagen, Silicone, Juvederm, Artefill or any other Cosmetic/ Plastic Surgery Procedures performed on your face or have scheduled in the future? If so, Which procedure(s?) Where on your face? When performed or scheduled?)_____ _____
Were you pleased with your result(s?) /any complications/concerns?_____
Any medical concerns about procedure(s) you are interested in today?_____
Any Other medical conditions? _____

Cancellation Policy: If you cancel your appointment less than 24 hours before it is scheduled to take place, you will be subject to a non-refundable fee of $50.

Patient Photo Consent: I, the undersigned do hereby agree to allow Prescott Medical Aesthetics to take my photographs before and after my procedure to be stored into my patient chart.

_____ _____
Signature Date