AGELESS SKIN & HEALTH SOLUTIONS

Dr. Elaine Burns

AESTHETIC MEDICAL HISTORY

Name : _____ DOB: _____ Date : _____

Address _____

City _____ State _____ Zip _____

Home Phone _____ Work/Cell Phone _____

Primary Physician's Name and Number _____

_____

Please list all medications/supplements you are taking: _____

_____

List any allergies: _____ Are you on any antibiotics at this time? _____

Are you taking any muscle relaxants, allergy, cold or sleeping medication? _____

Circle any of the following illnesses you have or have ever had in the past:

Myesthenia Gravis Hepatitis Eye Disease Autoimmune Disease Vision Problems

Numbness Muscle Weakness Multiple Sclerosis Amyotrophic Lateral Sclerosis (ALS)

Parkinson's Disease Neurological Disorders Lambert-Eaton Syndrome

List and/or Explain Other Medical Conditions not listed above such as diabetes, bleeding disorders, respiratory , heart or, eye :_____

_____

_____

Previous Hospitalizations/Operations: _____

_____

WOMEN: Are you Pregnant, Trying to get Pregnant, or Lactating (nursing)? _____

Have you had Plastic Surgery or other surgery to your face/neck areas and when? _____

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Had Botulinum injections / FILLERS / used LATISSE in the past: Yes / No

Which Product: Botox/Dysport/Myobloc /RESTYLANE/PERLANE/JUVEDERM / LATISSE / OTHER:

_____

Date of last treatment: _____ Area (s) treated: _____

Any negative results with any of these ? Explain: _____

Ever had eyelid/eyebrow drooping after Botulinum®? Yes / No Explain: _____

_____

Have you ever had any NEGATIVE results after ANY medical cosmetic treatment? Yes No / Explain:

_____

_____

_____

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 the office as soon as possible. I have read and understand the 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 completion of this form.

Patient Signature _____ **Date**_____

Print Name: _____