



## PATIENT INFORMATION

### BASIC PERSONAL INFORMATION

FIRST NAME:		MIDDLE NAME:	
LAST NAME:		SEX	
DATE OF BIRTH:		_____ MALE	_____ FEMALE
HOME PHONE:		CELL PHONE:	
EMAIL:			
HOME ADDRESS:			
CITY:	STATE:	ZIP CODE:	
MAILING ADDRESS: (If different than Home)			
CITY:	STATE:	ZIP CODE:	

### CONTACT INFORMATION

FIRST NAME:			
LAST NAME:			
RELATIONSHIP TO YOU:			
PHONE:	EMAIL:		
ADDRESS:			
CITY:	STATE:	ZIP CODE:	

### HOW WAS YOU REFERRED TO US?

- FRIEND: NAME: \_\_\_\_\_
- INTERNET WEBSITE: \_\_\_\_\_ GOOGLE SEARCH \_\_\_\_\_ FACEBOOK \_\_\_\_\_ TIKTOK \_\_\_\_\_ INSTAGRAM
- WALKING BY
- OTHER (PLEASE SPECIFY): \_\_\_\_\_

### TREATMENT REQUESTED

BOTOX	LASER SKIN REJUVENATION
FILLER (VOLUMA, JUVEDERM)	ACNE
MICRO NEEDLING	HORMONES
ACNE SCARS	INJECTIONS
PIGMENTATION/ BROWN SPOTS/ SUN DAMAGE	IV THERAPY
WRINKLE REDUCTION	WEIGHT MANAGEMENT
PRP	SEXUAL WELLNESS
LASER HAIR REMOVAL	HAIR RESTORATION
HYDRA FACIAL	OTHER:

MAY WE CONTACT YOU FOR PROMOTIONS VIA EMAIL AND OR TEXT?    YES / NO



## GENERAL HEALTH HISTORY

Are you currently under the care of a physician? YES / NO

If yes, for what reason? \_\_\_\_\_

Any Medications? Vitamins, Herbs, or Ointments? YES / NO

If yes, name of Medications? \_\_\_\_\_

### USES

Tabacco: YES / NO      Amount: \_\_\_\_\_      Coffee/ Tea/ Soda: YES / NO      Amount: \_\_\_\_\_

Alcohol: YES / NO      Amount: \_\_\_\_\_      Daily Exercise: YES / NO      Amount: \_\_\_\_\_

Ibuprofen: YES / NO      Amount \_\_\_\_\_      Daily Aspirin: YES / NO      Amount: \_\_\_\_\_

### ALLERGIES

Seasonal allergy: YES / NO

Medication Allergy: YES / NO Name & Reaction-\_\_\_\_\_

Latex Allergy: YES / NO Source & Reaction-\_\_\_\_\_

Tape Allergy: YES / NO Type & Reaction-\_\_\_\_\_

### MEDICAL HISTORY

#### DO YOU HAVE OR HAD ANY OF THE FOLLOWING?

YES	NO		YES	NO	
		High Blood Pressure			History of Kidney Stones
		Heart Attack			Ulcers
		Irregular Heartbeat			Reflux/ Heartburn
		Cardiac/ Disease			Pancreatitis
		High Cholesterol			Arthritis
		Heart Disease			Muscle Weakness
		Respiratory Illness			Hepatitis
		Sleep Apnea			HIV/ Aids
		Asthma			Head Injury/ Stroke
		History of Lung Problems			Seizures
		UTI			Depression
		Bleeding/ Blood Clotting Problems			Headaches
		Diabetes			Breast Masses
		Thyroid			Other:
		Cancer			

If yes to Any Responses Please Describe: \_\_\_\_\_

### SKIN

Are you currently under the care of a dermatologist? YES / NO

If yes, for what? \_\_\_\_\_

Have you had any recent tanning, use of self-tanning lotions, or sun exposure that changed the color of your skin? YES / NO

Do you use tanning booths? YES / NO

Do you form thick or raised scars? YES / NO

Do you have any thick or raised scars? YES / NO

Do you have Hyper Pigmentation (darkening of the skin) or Hypo Pigmentation (lightening of the skin) or marks after physical trauma?

YES / NO If yes, please describe: \_\_\_\_\_

Do you have Melasma (patchy brown discoloration of skin when heat is present)? YES / NO

If yes, what area or areas? \_\_\_\_\_

Have you ever taken Accutane? YES / NO

Do you use any Acne Medication? YES / NO

If yes, Pleas list: \_\_\_\_\_

**Skin Type**

<input type="checkbox"/>	Sunburn Easily	<input type="checkbox"/>	Sun burn, then Tan
<input type="checkbox"/>	Usually, Tan	<input type="checkbox"/>	Always Tan
<input type="checkbox"/>	Sensitive	<input type="checkbox"/>	Oily
<input type="checkbox"/>	Dry	<input type="checkbox"/>	Normal

**Pregnancy**

Are you currently pregnant? YES / NO

Have you been pregnant? YES / NO

Pregnancies? \_\_\_\_\_ Births? \_\_\_\_\_

Are you currently Breast feeding? YES / NO

Are you planning on getting pregnant soon? YES / NO

Are you currently taking birth Control? YES / NO

If yes, What kind of Birth Control (pills, IUD, condoms)? \_\_\_\_\_

**SURGERIES**

Do you have any scheduled surgeries? YES / NO

If yes, for what? \_\_\_\_\_

Have you received any surgeries? YES / NO

If yes, What Procedures and Dates? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**All Patients:**

I certify that the preceding medical, personal, and skin history statements are true and correct. I am aware that it is my responsibility to inform the technician, esthetician, therapist, doctor, or nurse of my current medical or health conditions and to update this history. A current medical history is essential for the caregiver to execute appropriate treatment procedures.

Print name: \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_

PATIENT NAME: \_\_\_\_\_ DOB: \_\_\_\_\_

**DO YOU HAVE?**

YES	NO		YES	NO	
		Hypersensitivity to botulinum a toxin product			Infection at the proposed injection site(s)
		Active skin disease			Amyotrophic lateral sclerosis
		Motor neuropathy			Myasthenia gravis
		Lambert-Eaton syndrome			Facial nerve palsy

**DO YOU TAKE OR HAVE RECENTLY BEEN ON ANY OF THE FOLLOWING MEDICATIONS?**

YES	NO		YES	NO	
		Warfarin or anti-platelet agents (aspirin, Plavix)			Quinidine (treats malaria and irregular heartbeats)
		Aminoglycosides (antibacterial med)			Magnesium sulfate (used for short term relief)
		Curare-like nondepolarizing blockers(steroidal)			Anticholinesterases (Alzheimer's medications)
		Lacosamide's (antibiotics)			Succinylcholine chloride (neuromuscular blocker)
		Polymyxins (antibiotic)			

**\*\*STOP HERE**
**AND SIGN BELOW\*\***
**\*\* TO BE COMPLETED BY MD, NP, OR PA \*\***

- 
- Medical history and current medications have been reviewed.

Relative medical history: \_\_\_\_\_

- 
- Intake Form reviewed.
- 
- 
- Patient is not taking Contraindicated medications.
- 
- 
- Client is not Pregnant or Breastfeeding.

LMP: \_\_\_\_\_ LAST PAP: \_\_\_\_\_

- 
- Patient is determined to be healthy enough to be considered low risk for complications.

Limited Physical Examination: \_\_\_\_\_

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- No known hypersensitivity or reactions to medications.

Allergies and Reactions if so: \_\_\_\_\_

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- Patient has no bleeding or clotting disorders. Patient has been advised to avoid alcohol, aspirin, and non-steroidal anti-inflammatories prior to the procedure.

Patient has bleeding and bruising risk: \_\_\_\_\_

- 
- Patient has no Cardiac risk factors such as arrhythmia or severe coronary artery disease that could be worsened by medical procedures.

Patient has Cardiac Risk Factors: \_\_\_\_\_

YES	NO		YES	NO	
		Glabella lines smoothed out by spreading apart			Skin infection at site of injection
		Evidence of muscular atrophy			Evidence of petechia or bruising
		Facial asymmetry			Ptosis
		Deep dermal scarring			Thick sebaceous skin
		Dermatochalasis			

**Comments:**

Upon Review of the available information regarding patient's current and past medical history, medications, and overall physical health profile our Medical Professionals have reasonable medical certainty to proceed with the treatment plan offered at Optimal Wellness & Aesthetics. Understanding that a patient's medical history and medications may change over time requires updates and evaluation by our clinicians for any current and future treatments. It is a duty and obligation for patients to inform and the treating clinicians to update any recent changes in their medical history to ensure the safety of on-going medical aesthetic treatment plans. Authorization will be obtained prior to treatment. If there are changes in medical conditions, new medications, or concerns about any increased complication risk based on the information listed above.

The signature of this document represents that a medical review and evaluation has been performed. It has been determined that there is reasonable and medical certainty insuring a low acceptable risk profile related to any procedures provided by Optimal Wellness and Aesthetics.

Patients Name: \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Physician signature: \_\_\_\_\_ Date: \_\_\_\_\_