Aesthetic Institute of West Florida

Confidential Patient Health History Form

Date: _____

Name: _____ DOB:_____

Address:_____ City:_____ Zip:_____

Home Phone: _____Cell Phone:_____

Email Address: _____

Emergency Contact: _____ Phone:_____

Approval to contact you? ☐ No ☐ Yes Referred by: _____

1) Have you been under the care of a physician, dermatologist or other medical professional within the past year?
☐ No ☐ Yes, explain: _____

2) Have you had any surgeries, including plastic surgery?
☐ No ☐ Yes, explain: _____

3) Have you ever had ☐ Botox, ☐ fillers, or ☐ facial lasers? If so, when? _____

4) List any medications (including prescription skin care products, acne medication, birth control, etc.)
you take regularly:_____

5) List any over the counter medications (including vitamins, herbal supplements, aspirin, etc.)
you take regularly:_____

6) List any known drug allergies:_____

7) Have you ever had any of these health conditions in the past or present?
(Please check all that apply and provide additional information in the space provided)

Cancer _____(type)	☐	Headaches (chronic)	☐
Hormone imbalance	☐	Hepatitis	☐
High blood pressure	☐	Fever blisters/Cold sores	☐
Spinal injury	☐	Immune disorders	☐
Thyroid condition	☐	HIV/AIDS	☐
Thyroid condition	☐	Metal bone pins or plates	☐
Diabetes	☐	Blood clotting abnormalities	☐
Heart problem	☐	Psychological treatment	☐
Arthritis	☐	Skin diseases/skin cancer _____(type)	☐
Asthma/Breathing problems	☐	Any active infection	☐
Keloid scarring	☐	Any eye problems	☐
Seizure disorder	☐		

Any other medical problems: _____

_____

8) Do you smoke? ☐ No ☐ Yes

9) Do you drink alcohol? ☐ No ☐ Yes If yes, how much do you drink? _____/day _____/week

10) Have you ever had an allergic reaction to any of the following?
(Please check all that apply and provide additional information in the space provided)

Cosmetics	☐	Medicine	☐
Skin Care Products	☐	Latex	☐
Fragrance	☐	Iodine	☐
Sunscreens	☐	AHAs (alpha-hydroxy acids)	☐
Food	☐	Drugs	☐
Shellfish	☐	Pollen	☐
Animals	☐		

Other: _____

If yes, please explain:_____

11) Do you form thick or raised scars from cuts or burns? ☐ No ☐ Yes

12) Do you have Hyperpigmentation (darkening of the skin) or Hypopigmentation (lightening of the skin) or marks after physical trauma? ☐ No ☐ Yes, describe: _____

13) How often are you exposed to the sun or use a tanning bed? ___Infrequently ___Frequently ___ Regularly

14) What SPF do you use on your face? _____ How often/when?_____

15) Have you recently used any self-tanning lotions, creams or treatments? ☐ No ☐ Yes, specify:_____

16) Have you used any of the following hair removal methods in the past six weeks? ☐ No ☐ Yes

Shaving	☐	Electrolysis	☐
Waxing	☐	Stringing	☐
Plucking	☐	Depilatories	☐
Tweezing	☐		

17) Have you ever had a body spa treatment before? ☐ No ☐ Yes, when: _____

18) What skin care products are you currently using? (List brand where known)

Soap _____	Shower Gels _____
Toner _____	Body Lotions _____
Mask _____	Sunscreen _____
Eye Product _____	Night Moisturizer/Cream _____
Cleanser _____	Day Moisturizer _____
Exfoliator _____	Scrubs _____

Makeup Products _____

Other _____

19) What areas of concern do you have regarding your: (Please check any that apply)

Skin:

Breakouts/acne	☐	Uneven skin tone	☐
Blackheads/whiteheads	☐	Sun damage	☐
Excessive oil/shine	☐	Wrinkles/fine lines	☐
Rosacea	☐	Dull/dry skin	☐
Broken capillaries/redness	☐	Flaky skin	☐
Sun spot/liver spot/brown spot	☐	Dehydrated	☐
Thin eyelashes	☐		

Eyes:

Dehydrated ☐ Wrinkles ☐ Puffiness ☐ Dark circles ☐ None ☐

Other:_____

Lips:

Dehydrated ☐ Cracked/chapped lips ☐ None ☐ Other: _____

20) I would like to know more about:

Please check all that apply:

☐ Eyelash length, fullness, thickness, or darkness	☐ Skin care products/advice
☐ BOTOX® Cosmetic for wrinkles	☐ Thin lips
☐ Facial Fillers (Restylane, Juvederm, Perlane, Radiesse, Sculptra)	☐ Facial veins/redness
☐ Cosmetic Eyelid surgery/Droopy eyelids	☐ Liver spots/age spots
☐ Laser Skin Resurfacing or other treatments	☐ Kybella for chin contouring
☐ Volume loss/facial hollows	☐ _____

Female Clients Only:

21) Are you taking oral contraceptives? ☐ No ☐ Yes, specify: _____

22) Are you pregnant or trying to become pregnant? ☐ No ☐ Yes

23) Are you breast feeding? ☐ No ☐ Yes

I understand, have read and completed this questionnaire truthfully. I agree that this constitutes full disclosure, and that it supersedes any previous verbal or written disclosures. I understand that withholding information or providing misinformation may result in contraindications and/or irritation to the skin from treatments received. I am aware that it is my responsibility to inform the aesthetician/doctor of my current medical or health conditions and to update this history. The treatments I receive here are voluntary and I release this institution and/or skin care professional from liability and assume full responsibility thereof.

_____ _____

Client Signature Date