Alouf Aesthetics Patient Medical History

Name: ______________________________ Today's Date: ____________

Address: ____

City: __________________________ State: __________ Zip: ________

Email: __________________________ Date of Birth: ______________

Home Phone: ____________________ Business Phone: ______________

Cell # or Preferred Contact #: ______________Is it important to be discreet? ________

Occupation____________________Employer____________________

Emergency Contact____________________Phone#__________________

How did you hear about us? ____________________________________

Describe the nature of your visit:________________________________

Please fill out all of the following that may apply:

Medical History:

Primary Care Physician______________________Phone Number__________

Do you have any Medical Problems? No: _____ Yes: _____ If yes, list below:

List all **Medical Problems**:____________________________________

____

____

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____

Heart Condition: _________If yes, please explain___________________________

Diabetes: ______If yes, please explain______________________________

Pregnant or Lactating: ______If yes, please explain__________________________

History of Skin Cancer______If yes, please explain__________________________

Have you ever had a **Cold Sore**?_______, do you get **Cold Sores p**eriodically?______________

History of **Bleeding disorder** or **uncontrolled bleeding** _____ If yes, please explain __________

____

Have you ever had a **Blood Clot**? ______ If yes, please explain____________________

____

List all **Surgeries and dates:**

____

____

____

Major Allergies (please check):

Milk_______Sugar/Beets_______Retinoic acid_______Aspirin_______Grapes_______ Apples_______

Tomatoes______Citric fruits______

Please List All **Medication Allergies**: ____

____

____

Do You have problems with **Lidocaine** or **Numbing Medicines at the Dentist**?______________________

If so, please explain: ____

List all **Medications** you are currently taking (blood thinners, antibiotics, herbs, supplements, vitamins, aspirin, birth control etc): ____

____

____

Have you been on Accutane in the past 6 months? ____

Include any other medications that make you photo sensitive: ____________________________________

Skin Background:

Have you had prolonged sun exposure (or tanning bed) in the past 3 days? ___Yes ___No

If so, are you currently sunburned? ______Yes ______No

Do you use tanning beds? ______Yes ______No

Are you using chemical tanning solutions? ______Yes ______No

Do you use sunscreen on a regular basis? ______Yes ______No

Check any Skin Conditions that may apply:

Acne _____Yes _____No

If so, what is the frequency of your breakouts? _____ Frequent _____Occasional _____ Rarely

Do you experience cystic breakouts? _____ Yes _____ No

Do you have any scarring as a result from your acne? _____ Yes _____ No

Breakouts	_____Yes _____No	Rosacea	_____Yes _____No
Perm Makeup/Tattoos	_____Yes _____ No	Fine Lines	_____Yes _____No
Scars	_____Yes _____No	Wrinkles	_____Yes _____No
Texture	_____Yes _____No	Dryness	_____Yes _____No
Eczema	_____Yes _____No	Dermatitis	_____Yes _____No
Allergies	_____Yes _____No	Spider Veins	_____Yes _____No
Hyperpigmentation	_____Yes _____No	Sun Damage	_____Yes _____No
Unwanted Follicles	_____Yes _____No	Cold Sores/Herpes	_____Yes _____No

Current Skin Care Regime & Products Used:

____

____

____

Skin Type (please circle):

Caucasian Hispanic Mediterranean African American American Indian

Other: ____

Have you had Botox, Dysport or Filler injections in the past 6 months? _____ Yes _____ No

If yes and less then 3 months, approximate dates? _______________________________________

Do you use topical ointments? _____ Retin-A _____ Glycolic _____ Lactic Acid

_____ Hydroquinone _____ Other: ____

Do you exercise? ______Yes ______No

Do you smoke? ______Yes ______No If yes, how many packs per day____________

Do you Drink Alcohol? ______Yes ______No If yes, how frequently _______________

Check other services of interest:

_____ Awake Liposuction/Smart Lipo®

_____ Fat Transfer

_____ HCG Diet

_____ Laser Hair Removal (list different areas) _________________________________

_____ Laser Vein Removal / Sclerotherapy

_____ Non-ablative LaserFACIAL (facial rejuvenation, Acne, Rosacea, redness, fine lines & wrinkles)

_____ Pigmented Lesions or Brown Spot Removal

_____ Laser Mole Removal

_____ Ear Lobe Repair

_____ Botox®/Dysport®

_____ Restylane®/Perlane®/Radiesse®/Juvederm Ultra®/Juvederm Ultra Plus® (filler for lip enhancement, fine lines & wrinkles)

_____ Laser Resurfacing (fine lines & wrinkles, acne scars, and facial rejuvenation)

_____ Microdermabrasion/ Chemical Peels

_____ Laser Facials/Acne

_____ Anti-aging skin care products and gloMinerals® makeup

_____ Masssages

_____Bio-Identical Hormone Replacement Therapy

Other: ____

I certify that the above medical history information is accurate and correct:

_________________________________ _________________________________

(Responsible Party- Print Name) (Signature)

_________________________________ _________________________________

(Relationship to patient if minor) (Date)