



Alouf Aesthetics Patient Medical History

ALOUF AESTHETICS

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 discrete? _____

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**:

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** periodically? _____

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 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:

- ____ 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
- ____ Botox®
- ____ Restylane®, Juvederm® (filler for lip enhancement, fine lines & wrinkles)
- ____ Laser Resurfacing (fine lines & wrinkles, acne scars, and facial rejuvenation)
- ____ Mesotherapy (cellulite)
- ____ Microdermabrasion/ Chemical Peels
- ____ Laser Facials/Acne
- ____ TriActive™ Laser (cellulite reduction)
- ____ Curl-Lift (minor surgical face lift)
- ____ Anti-aging skin care products and gloMinerals® makeup
- ____ Face Lift
- ____ Safe Liposuction/Smart Lipo®
- ____ Tummy Tuck (Safe Awake)
- ____ Masssages
- ____ Fat Transfer
- Other: _____

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

(Responsible Party- Print Name)

(Signature)

(Relationship to patient if minor)

(Date)