Mountain West Aesthetics

PATIENT INFORMATION

Name ____ Date __________________

Date of Birth __________________ Age _________ Occupation ____________________________

Address _________________________________City ____________ State ______ Zip_________

Cell Phone: _______________ Work Phone _______________Email ________________________

Primary Physicians Name ______________________________ Phone ______________________

Emergency Contact Name ______________________________ Phone ______________________

How were you referred to us? ____

What are your cosmetic goals? ____

What are we seeing you for today? ____

Have you had Botox/Dysport or Facial Fillers before? **YES/NO** If yes, what? ______________________

What products or treatment are you currently using to treat your skin? ________________________

____

MEDICAL HISTORY

Are you currently under the care of a physician? **YES/NO** If yes, for what?______________________

Previous Hospitalizations/Operations/Facial Surgery_______________________________________

____

Please list **ALL** medications including vitamins or supplements you are currently taking regularly or have taken in the last 24 hours ____

____

List **ALL** Allergies: ____

Do you have any of the following medical conditions? (Please mark YES or No to all)

PLEASE CHECK ALL THAT APPLY:	YES	NO		YES	NO
Cancer			Frequent cold sores		
High Blood Pressure			Herpes		
Arthritis			Skin Lesions		
HIV/AIDS			Keloid scaring		
Skin Disease			Auto Immune Disease		
Seizure Disorder			HIV, Hepatitis		
Hormone Imbalance			Lupus		
Blood Clotting Abnormalities			Any active Infection		
Heart Conditions			Thyroid Imbalance		
Are you pregnant or nursing?			Multiple Sclerosis (MS)		
Are you using contraception?			Amyotrophic Lateral Sclerosis (ALS)		
Diabetes			Parkinson’s		

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

Signature ____ *Date* __________________________