MEDICAL AESTHETICS

HINGHAM | EASTON | MILTON

HEALTH HISTORY FORM

WWW.MEDICALAESTHETICSMA.COM

HINGHAM
38 North Street
Hingham, MA 02043
781.556.5676

EASTON
244 Washington Street
North Easton, MA 02356
508.219.2113

MILTON
524 Adams Street
Milton, MA 02186
617.322.1852

Date:_____

Name:_____ DOB:_____ Age:_____

Gender: ☐ Male ☐ Female ☐ Other Marital status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced

Address:_____ City:_____ State:_____ Zip: _____

Home Phone:_____ Cell:_____ Work: _____

Emergency Contact:_____ Contact's Phone:_____

Email: _____

Employer:_____ Occupation:_____

Pharmacy:_____ Pharmacy Phone: _____

MEDICAL HISTORY Have you ever been diagnosed or treated for any or the following conditions? No / Yes (Please check all that apply.)

☐ Acne	☐ Heart disease / cardiac arrest	☐ Myasthenia Gravis
☐ Auto-immune disorder	☐ Herpes Simplex / cold sore	☐ Neurological problem
☐ Blood disorder - bleeding	☐ High blood pressure	☐ PCOS / ovarian cysts
☐ Blood disorder - clotting	☐ Hirsutism	☐ Psoriasis
☐ Burns / skin grafts	☐ HIV	☐ Psychiatric disorder
☐ BPH (males)	☐ Hormone imbalance	☐ Scarring issue / keloid scarring
☐ Cancer	☐ Hyperpigmentation	☐ Stroke
☐ Diabetes	☐ Kidney disease	☐ Thyroid disorder
☐ Dizziness / fainting	☐ Muscle weakness	☐ Vitiligo

If you checked any of the above boxes, please explain:

_____

_____

Are you currently pregnant, trying to conceive or nursing?

Do you smoke? ☐ Never ☐ Occasionally ☐ Regularly ☐ Frequently

Do you drink alcohol? ☐ Never ☐ Occasionally ☐ Regularly ☐ Frequently

Sun Exposure history? ☐ Never ☐ Occasionally ☐ Regularly ☐ Frequently

ALLERGIES

Medications:

_____ Reaction:_____

Food:

_____ Reaction:_____

Latex:

_____ Reaction:_____

Skin Sensitivities:

_____ Reaction:_____

Have you ever experienced anaphylaxis? ☐ no ☐ yes

_____

MEDICATIONS

Please list your current medications: ☐ no ☐ yes

_____

Please list your current over the counter (OTC) medications or vitamins and / or supplements:

_____

Please list your current topical medications:

_____

Please list your current cosmetic / derrnatologic product usage:

Have you received Accutane therapy in the last 12 months? ☐ no ☐ yes _____

Have you ever been treated with a neurotoxin (Botox®, Dysport®, Xeomin®)? ☐ no ☐ yes _____

Have you ever been treated with dermal filler (Juvederm®, Restylane®, etc)? ☐ no ☐ yes _____

SURGERY OR HOSPITALIZATION

☐ Cosmetic:

☐ Therapeutic:

☐ Hospitalization (Please explain why and when):

Primary Care Physician:

Name: Address:

Please sign below to indicate all the information on this form is accurate and complete to the best of your knowledge.

Signature: Date:

Printed Name: Date:

Witness signature: Date: