Aesthetica Cosmetic & Laser Surgery Center
PATIENT HISTORY

Patient Name**:** _____ Date: _____ Age**:** _____

Main Concern: _____ Referring doctor: _____

MEDICATIONS: Anticoagulants (ex. ASA, ibuprofen, Coumadin, Xarelto, etc) _____

Prescription: _____

Non-Prescription:_____

Supplements/Vitamins (including Fish Oil): _____

SKIN CARE: _____

ALLERGIES:
____Lidocaine ____Novocain
____Food Allergies
____Seasonal/Environmental
____Other Allergies _____

P.H.: ___Smoking: # per day ___
___Alcohol: how often ___

MEDICAL HISTORY: (*please check what applies to you*)
____Hypertension
____Heart Murmur
____Heart Arrhythmias (ex, A-fib, palpitations)
____HIV Exposure
____Prophylactic Antibiotics
____HX Abnormal Bleeding, Bruising, Scarring
____Pacemaker or ICD Implant
____Skin Cancer: Type_____
Location_____
____Gold Therapy
____Metal Implants (Location_____)
____Tanning HX:
Type_____ Year____
Natural Tanning # of exposures_____
Artificial Tanning # of exposures_____

___Diabetes
___HX Hepatitis (Type___)
___ Epilepsy or seizures
___GI disorder
___Herpes Simplex Virus (Cold Sores)
___Wear contacts
___Glaucoma, Cataracts, or dry eyes
___Menopause: # of years____

___ Other medical condition(s) not listed: _____
___ Permanent/Cosmetic Tattoo
___ Dental Work: Type_____ Year____

SURGERIES: (Cosmetic and Other)

_____

_____

I hearby acknowledge that all information on this form is complete and true to the best of my knowledge.

Patient/Legal Guardian:_____ Date: _____