

**NEW CLIENT**

Client Name: \_\_\_\_\_

**MEDICAL HISTORY**

1. Please list any drug allergies or sensitivity: \_\_\_\_\_  
\_\_\_\_\_
2. Have you ever used/are you currently using any of the following? (check all that apply)  
 Retin A     Renova     Accutane     Prescription Acne Medicine  
 Steroids     Birth Control Pills     Depo Shot
3. Please list all prescription and non-prescription medication or herbal supplements that you are currently taking: \_\_\_\_\_  
\_\_\_\_\_
4. Women, Are you pregnant or breast-feeding?  Yes  No
5. Please list any chronic conditions that are currently treated by your primary care provider: \_\_\_\_\_
6. Please list any past hospitalizations or surgeries: \_\_\_\_\_  
\_\_\_\_\_
7. Please list any past cosmetic facial treatments or facial surgeries and any complications or reactions \_\_\_\_\_
8. Have you ever had or been treated for: (check all that apply)

<input type="checkbox"/> Cancer <input type="checkbox"/> Diabetes <input type="checkbox"/> Dizziness/Fainting <input type="checkbox"/> Epilepsy <input type="checkbox"/> Head Injury	<input type="checkbox"/> Headaches/Migraine <input type="checkbox"/> HIV/AIDS <input type="checkbox"/> Melanoma <input type="checkbox"/> Mental Disease	<input type="checkbox"/> Multiple Sclerosis <input type="checkbox"/> Muscle Problems <input type="checkbox"/> Nerve Injury <input type="checkbox"/> Skin Rash/Disease
--	--	--
9. Do you smoke?  No     < 1 pack per day     1 pack or more per day
10. Have you ever had cold sores or fever blisters?  Yes    How Often? \_\_\_\_\_
11. How often do you suntan? \_\_\_\_\_

*Form continued on back*

