

Horizons



Wellness

Medical History for Aesthetic Services

Name: _____ Date: _____

Date of Birth: _____ Age: _____ Male/ Female: _____ Phone: _____

Address: _____ EMAIL: _____

How did you hear about our practice? _____

Have you had in the past or do you currently have:

Pigmentation issues, hyper or hypo pigmentation	Y	N	Heart Disease	Y	N
Diabetes	Y	N	Irregular Pulse	Y	N
Gold Therapy	Y	N	Fainting Spells	Y	N
Seizure Disorder (Epilepsy)	Y	N	Asthma	Y	N
High Blood Pressure	Y	N	Keloid Formation	Y	N
Polycystic Ovarian Syndrome	Y	N	Rosacea	Y	N
Irregular Menses	Y	N	Lupus	Y	N
Thyroid Disorder	Y	N	Hepatitis	Y	N
History of Herpes Simplex infections/fever blisters	Y	N	Chemotherapy	Y	N
Acne	Y	N	Skin Cancer	Y	N
Are you Photosensitive?	Y	N	Have you ever used Retin-A ?	Y	N
Have you ever had a chemical peel or microderm?	Y	N	Have you ever taken Accutane ?	Y	N
Do you have any Tattoos or permanent makeup?	Y	N	Cancer	Y	N
Have you ever had any laser treatments?	Y	N	Other medical issues or illnesses	Y	N

Medication: (Please list any medication you are currently taking including herbal supplements and vitamins.)

What topical medications or creams are you currently using? Retin -A, Others?

Are you taking mood altering or anti-depression medication? Y N

Are you under the care of a physician? Y N If yes, why? _____

Drug Allergies: (please list any know drug allergies): _____

Have you had any recent tanning, sun exposure or used tanning creams that changed the color of your skin? Yes NO

Do you use sunscreen? ____ What SPF? ____ Do you scar easily? ____ Do you heal quickly? ____

Have you used any of the following hair removal methods in the past six weeks?

Shaving? ____ Waxing? ____ Electrolysis? ____ Tweezing? ____ Threading? ____ Depilatories? ____

Please mark area(s) of interest:

Hair Removal _____

Brown spots _____

Wrinkles _____

Rosacea _____

Facial veins _____

Skin resurfacing _____

What treatment would you like to discuss today? _____

For our female patients:

Are you pregnant or trying to become pregnant? Y N

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I certify that the preceding medical, personal and skin history statements are true and correct. I am aware that it is my responsibility to inform the staff at Horizons Health and Wellness, LLC and Horizons Wellness, LLC of my current medical or health conditions and to update this history with any changes that may occur. A current medical history is essential for the caregiver to execute appropriate treatment procedures

Signature: _____ **Date:** _____