



The Aesthetic and Wellness Center, PLC

3825 State Road 64 East Ste. # 300 Bradenton, FL 34208 941-749-0741

MEDICAL HISTORY

Name: _____ Age: _____ Birth date: _____
 Today's Date: _____ Last Physical/Bloodwork: _____
 Primary Physician's Name: _____
 Office phone # (Primary Care Physician): _____

What is your reason for your visit today?

___ Aesthetic Services ___ Weight Management ___ Mesotherapy

General Health History

- | | | |
|-------------------------------|---------------------------|--------------------------|
| ___ Autoimmune Deficiency | ___ Heart Attack | ___ Neurological Disease |
| ___ Anorexia/Bulimia | ___ Heart Disease | ___ Pacemaker |
| ___ Arthritis | ___ High Cholesterol | ___ Palpitations |
| ___ Asthma | ___ HIV/AIDS | ___ Psychiatric Care |
| ___ Bleeding Disorder | ___ Anemia | ___ Rheumatoid Fever |
| ___ Cancer | ___ Hypertension | ___ Skin Allergies |
| ___ Chemical Dependency | ___ Infection (active) | ___ Stroke |
| ___ Cold Sores/Fever Blisters | ___ Keloid Scar Formation | ___ Thyroid Disease |
| ___ Depression | ___ Kidney Disease | ___ Other |
| ___ Diabetes | ___ Liver Disease | _____ |
| ___ Emphysema/COPD | ___ Lung Disease | _____ |
| ___ Epilepsy/Seizures | ___ Migraine Headaches | _____ |
| ___ Gastric Reflux | ___ Multiple Sclerosis | _____ |

Allergies

- * Medications: _____
 * Food: _____
 * Cosmetics: _____
 * Latex/Other: _____
 * Are you allergic to: ___ Lidocaine ___ Beef ___ Strawberries ___ Eggs/Chicken ___ Collagen

Current medications

Social History

___ Single ___ Married ___ Widowed
 Occupation: _____
 Do you smoke cigarettes? _____
 If yes, how many packs a day: _____
 Weekly alcohol intake: _____

Women only:

Date of last menstrual period: _____

Are you currently using contraception? _____

Are you pregnant? _____

Are you currently on hormonal replacement? _____

Are trying to get pregnant? _____

If yes, please provide name of medications: _____

Are you nursing? _____

Family History: Check if any of your blood relatives have had any of the following:

___ None ___ Cancer ___ Diabetes ___ Heart Disease/Stroke ___ Kidney Disease

___ Obesity ___ High Blood Pressure Other: _____

History of previous cosmetic treatments or procedures:

___ Ablative Laser

___ Laser Acne Treatments

___ Botox

___ Laser/IPL Hair Removal

___ Cellulite Reduction

___ Mesotherapy

___ Chemical Peels

___ Microdermabrasion

___ Dermal Fillers

___ Permanent Make-Up

___ IPL Fotofacial

___ Sclerotherapy

When did you have it done? _____

Are you currently taking/using?

___ Retin-A ___ Renova ___ Steroids ___ Prescription acne medication

Have you been taking Accutane for the past 12 months? _____

What line of skin products are you using? _____

I understand the information on this form is essential to determine my medical and cosmetic needs and the provision of treatment. I understand that if any changes occur in my medical history/health I will report it to the office as soon as possible. I have read and understand the above medical history questionnaire. I acknowledge that all answers have been recorded truthfully and will not hold any staff member responsible for any errors or omissions that I have made in the completion of this form.

Print Name, Parent or Legal guardian

Date

Signature

Reviewed by/ Date