



**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        | ___ Gout/Hyperuricemia            |
| ___ Diabetes                  | ___ Liver Disease         | ___ Surgeries (Please list below) |
| ___ 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: \_\_\_\_\_  
 Do you drink alcohol: \_\_\_\_\_  
 If yes, 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  
\_\_\_ Medical Pedicure \_\_\_ VelaShape™  
\_\_\_ Skin Tightening

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