Medical History for Aesthetics

Dr. Valarie Overton

Patient Name:_____ **Date Of Birth:**_____ **Age:**_____

Address:_____

Street **City** **State** **Zip Code**

Cell #:_____ **Home #:**_____

Marital Status:_____ **SS #:**_____

Occupation:_____ **Employer:**_____

Emergency Contact:_____ **Relationship:**_____

Cell #:_____ **Home #:**_____

How do you heal after a cut or after surgery? (*Check one*)

☐Very Well ☐Thin Scar ☐Moderate Scar ☐Thick Scar ☐Keloid (Hypertrophic Scarring)

Have you undergone any of the following recently or in the past?

☐Botox injections ☐Juvederm injections ☐Restylane injections ☐Radiesse injections

☐Eyelid surgery ☐Face Lift ☐Electrolysis ☐Laser hair removal ☐Other:

Are You? Pregnant_____ Nursing_____

Do You? Smoke_____ Drink Alcohol_____ If yes, amount per day_____

Surgeries (*include date*):_____

ALLERGIES_____

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Medications *(Please check all that apply)*:

☐ Aspirin ☐ Advil ☐ Aleve ☐ Accutane ☐ Baby Aspirin ☐ Coumadin ☐ Fish Oil (Omega 3)

☐ Gingko ☐ Ginseng ☐ Motrin ☐ St. John's Wort ☐ Vitamin E

Please list all other medications you are currently taking:
(Including prescriptions and over the counter; vitamins, herbal medications, antibiotics such as aminoglycosides, penicillin or quinine)

_____

Do you have a history of:

☐ Auto-Immune Disorder ☐ Cold Sores/Fever Blisters ☐ Diabetes ☐ Double Vision ☐ Dry Eyes
☐ Excessive Bleeding ☐ Heart Disease ☐ High Blood Pressure ☐ Liver Disease ☐ Mental Disease
☐ Neuro-muscular disease ☐ Other:

The above information is true and accurate to the best of my knowledge

_____ _____

Patient Signature Date

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