NAKED FACE
MEDICAL BOUTIQUE
love your naked face

CLIENT INFORMATION & MEDICAL HISTORY

In order to provide you with the most appropriate treatment, we need you to complete the following questionnaire.
All information is strictly confidential.

PERSONAL INFORMATION

Client Name_____ Date _____

Date of Birth _____ Age _____Occupation _____

Home Address_____ City_____State _____ Zip_____

Home Phone _____Cell Phone _____ Email _____

Emergency Contact: Name_____ Phone_____ Relationship_____

How were you referred to us? _____

MEDICAL HISTORY

Primary Care Physician _____

Do you have any of the following medical conditions? (Please mark YES or NO to all)

PLEASE CHECK ALL THAT APPLY:	YES	NO		YES	NO
Cancer			Skin disease, or Acne?		
High Blood Pressure			Herpes/Frequent Cold Sores?		
HIV/AIDS, Hepatitis			Any active infection?		
Hepatitis			Keloid scarring		
Eye Disease or Vision Issues			Multiple Sclerosis (MS)		
Seizure Disorder			Amyotrophic Lateral Sclerosis (ALS)		
Diabetes			Parkinson's		
Blood Clotting Abnormalities			Myasthenia Gravis		
Heart Conditions			Lambert-Eaton Syndrome		
Thyroid Imbalance			Any other Neurological Diseases?		
Are you using contraception?			Lupus		
Are you pregnant or trying to get pregnant?			Rheumatoid Arthritis		
Are you breastfeeding?			Sjogren's Syndrome		
Any History of Anaphylaxis?			Any Other Autoimmune Diseases?		

*What oral prescription medications are you presently taking? _____

_____

List prior surgeries/hospitalizations_____

Have you ever had an allergic reaction to the following?

☐Food ☐Animal Protein ☐Aspirin ☐Lidocaine (Anesthetic) ☐Hydrocortisone ☐Human Albumin

☐Eggs ☐Latex ☐Hydroquinone or skin bleaching agents ☐Bee/Wasp Stings ☐Immunizations

☐ Medications _____ ☐ Other:_____

*Do you take any of the following medications/supplemements? (Please mark YES or NO to all)

	YES	NO		YES	NO		YES	NO
Aspirin			Blood thinners			COQ10		
Licorice			Flax seed			Vitamin E		
Fish Oil			Omega 3 fatty acids			Ginkgo biloba		
Garlic			Ginger			Cayenne		

FACIAL HISTORY

1) What areas of concern do you have today? ☐ **Forehead lines** ☐ **Frown lines/11's** ☐**Crows Feet**

☐**Flat/sunken cheeks** ☐**Lines around mouth/Smile lines** ☐**Lip appearance/texture** ☐ **Double Chin**

☐**Thinning Lashes** ☐ **Skin Appearance/Texture** ☐ **Other**_____

2) What are your expectations for today's visit? _____

3) Do you regularly sun bathe or use tanning salons? _____ How often? _____

4) What topical medications or creams are you currently using? ☐RetinA ☐Steroid Cream ☐Other

(Please list):_____

5) Have you ever had botox or dermal/lip fillers? YES / NO

If yes, When were you last treated: _____

Any complications? YES / NO If yes, please specify:_____

6) Have you taken any Aspirin, Ibuprofen/Motrin, Aleve/Naproxen Fish Oil, Vitamin E, Blood Thinners, Alcoholic Beverages in the last ten days? YES / NO

If yes, what? _____

7) Do you have any history of facial surgery, trauma, or implants? YES / NO

If yes, describe: _____

I certify that the preceding medical, medication and personal history statements are true and correct. I am aware that it is my responsibility to inform the doctor or other health professional of my current medical health conditions and to update this history. A current medical history is essential for the caregiver to execute appropriate treatment procedures.

*Signature*_____ *Date* _____