

Medical History

Name: _____

DOB: _____

Age: _____

Telephone: _____

Email: _____

Address: _____

Instagram: _____

MEDICAL HISTORY

Please list medications: (including prescription, oral, over the counter, topical, supplement or herbal)

Are you pregnant or lactating? (circle) Yes OR NO

Are you on any antibiotics? _____

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			Diabetes		
High Blood Pressure			Herpes		
Arthritis			Frequent cold sores		
HIV/AIDS			Keloid scarring		
Skin Disease (Dermatitis, Acne, Rosacea)			Skin Lesions		
Seizure Disorder, Epilepsy			Hepatitis		
Hormone Imbalance			Thyroid Imbalance		
Blood Clotting Abnormalities			Any active infection		
Heart Conditions			Rheumatoid Arthritis		
Parkinson's			Myasthenia Graves		
Multiple Sclerosis (MS)			Lambert-Eaton Syndrome		
Amyotrophic Lateral Sclerosis (ALS)			Hives		

BEAUTY MAISON

AESTHETICS

Any known allergies or allergic reactions to the following? (check the box)

☐ Animal Protein

☐ Aspirin

☐ Hydrocortisone

☐ Lidocaine (Anesthetic)

☐ Latex ☐ Eggs

☐ Bee Sting

☐ Hydroquinone or skin

☐ bleaching agents

Others allergies (medications, seasonal, foods): _____

Have you taken any Aspirin, Anti inflammatories (Ibuprofen, Motrin), Blood thinners, Herbal supplements (Fish Oil, Vitamin E, ginkgo, garlic, tumeric, ginseng) and Alcoholic Beverages in the last ten days? (circle) YES or NO If yes, what? _____

FACIAL HISTORY

Have you ever had Botox or dermal fillers? (circle) YES or NO

If yes, when were you last treated: _____

Product name: _____

Any complications? (circle) YES or NO

If yes, please specify: _____

FACIAL INJURY TRAUMA HISTORY

1) Any history of facial surgery? (circle) YES or NO

Describe: _____

2) Any history of trauma to the head or face? (circle) YES or NO

Describe: _____

Any TMJ problems? (circle) Pain Clenching Grinding

Any recent or scheduled in next two weeks dental treatment, date _____

Recent flu shot, date of injection _____

Other medical conditions: _____

Previous Hospitalization/ Operations? _____

Do you have plans for air travel within 24-48 hours? (circle) YES or NO

Future social events planned within the next 2 weeks? (circle) YES or NO

Have you ever had previous injections with (please indicate the most recent date and reactions):

Botulinum Toxin A _____

Hyaluronic acid fillers _____

Sculptra _____

BEAUTY MAISON

AESTHETICS

Which of the following best describes your skin type?

- ☐ Always burn, never tan
- ☐ Always burn, sometimes tan
- ☐ Sometimes burn, always tan
- ☐ Rarely burn, always tan
- ☐ Brown, moderately pigmented skin
- ☐ Heavily pigmented skin, very dark hair

Treatment Recommendations

Patients Concerns _____

Recommendations _____

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 clinic as soon as possible. I have read and understood the above medical 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.

Patient Name (Print)

Patient Signature

Date

I am the treating nurse/healthcare professional. I have reviewed this medical history with the patient and medical director.

Sonya Feskiv

Injector Name (Print)

Injector Signature

Date

Controlled Acts requiring authorization (see policy manual for directives)

- Neurotoxin - small area(5-25 botox units), medium area (25-50 botox units), large area (50-100 botox units)
- Dermal Fillers - small area (1-2 syringes), medium area (2-4 syringes), large area (4-6 syringes)
- Platelet Rich Plasma Treatment for Facial Rejuvenation or Hair Restoration
- Axillary Hyperhidrosis with Botox Therapeutic
- Deoxycholic Acid Treatments

I have performed a face-to-face with the above-named patient. All treatments discussed are authorized to Sonya Feskiv and performed according to the approved medical directives for neurotoxins, dermal fillers, platelet rich plasma, hyaluronidase, deoxycholic acid and xylocaine found in the office policy manual.

Medical Director: Ar-Jay Ordona CNO #: 14038141 Medical Director Signature: _____