BEAUTY MAISON
AESTHETICS

Medical History

Name:______________________ DOB: ______________________ Age:________
Telephone:______________________ Email: ______________________
Address:______________________ Instagram:______________________

MEDICAL HISTORY

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

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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		

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, ginko, 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 ____________________

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____

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Recommendations____

____

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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.

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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:**______________