MERIDIAN
aesthetics and wellness

MERIDIAN AESTHETICS AND WELLNESS

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AESTHETICS MEDICAL HISTORY FORM

Last Name: _____ First Name: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Telephone: Home: _____ Cell: _____ Email:_____

Date of Birth: _____ Gender: Female _____ Male ____ Other: _____

Family Doctor: _____ Phone: _____

Pharmacy: _____ Phone: _____

Emergency Contact: _____ Phone: _____

Which body area/areas or condition would you like treated? _____

_____

Please answer all of the following questions **YES** **NO**

1. Do you have **ANY** current or chronic medical illnesses? ☐ ☐

   Disclose any history of heat urticaria, diabetes, autoimmune disorders or any immunosuppression, blood disorders, cancer, bacterial or viral infections, medical conditions that significantly compromise the healing response, skin photosensitivity disorders, or <u>any</u> other condition or illness.

   Please List: _____

   _____

2. Do you have **ANY** current or chronic skin conditions? ☐ ☐

   Also disclose any history of vitiligo, eczema, melasma, psoriasis, allergic dermatitis, any diseases affecting collagen including Ehlers-Danlos syndrome, scleroderma, skin cancer, or <u>any</u> other skin condition.

   Please List: _____

   _____

3. Are you currently under a doctor's care? If so, for what reason? ☐ ☐

   _____

4. Do you take/use **ANY** medications (prescriptions and nonprescription), vitamins, herbal or natural supplements, on a regular or daily basis? ☐ ☐

   Please List: _____

   _____

5. Are there any topical products (both medical and non-medical) that you use on your skin on a regular or daily basis?

   Please List: _____

6. Do you take/use ANY systemic/oral steroids (e.g., prednisone, dexamethasone)? ☐ ☐

MEDICAL HISTORY, CONTINUED

		YES	NO
7.	Do you have **ANY** allergies to medications, foods, latex or other substances? Please List: _____	☐	☐
8.	(For women) are you or could you be pregnant?	☐	☐
9.	(For women) are menstrual periods regular, or have you ever been diagnosed with Polycystic Ovarian Disorder?	☐	☐
10.	Do you have a history of herpes I or II in the area to be treated?	☐	☐
11.	Do you have a history of keloid scarring or hypertrophic scar formation?	☐	☐
12.	Do you have a history of light induced seizures?	☐	☐
13.	Do you have history of melasma?	☐	☐
14.	Do you have any open sores or lesions?	☐	☐
15.	Do you have any history of radiation therapy in the area to be treated?	☐	☐
16.	In the last six (6) months, have you used any of the following: anticoagulants or blood-thinning medications; photosensitizing medications; or anti-inflammatory or blood thinning medications? Please List product name and date last used: _____ _____	☐	☐
17.	In the last three (3) months, have you used any of the following products: glycolic acid or other alphahydroxy or betahydroxyacid acid products; exfoliating or resurfacing products or treatments? Please List product name and date last used: _____ _____	☐	☐
18.	Do you have or have you ever had any permanent make-up, tattoos, implants, or fillers, including, but not limited to, collagen, autologous fat, Restylane®, etc.? If yes, please list locations on or in the body and dates: _____ _____	☐	☐
19.	Do you have or have you ever had any Botulinums, such as Botox®, Xeomin®, Jeuveau®, or Dysport®? If yes, please list locations on or in the body and dates: _____ _____	☐	☐
20.	Have you taken Accutane® (or products containing isotretinoin) in the last 12 months?	☐	☐
21.	Have you taken Tretinoin (like Retin-A®, Renova®) in the last 6 months?	☐	☐
22.	Have you had any unprotected sun exposure, used tanning creams (including sunless tanning lotions) or tanning beds or lamps in the last 4-6 weeks?	☐	☐
23.	Do you have an allergy to corn?	☐	☐
24.	Do you have an allergy to gold?	☐	☐
25.	Do you have any tattoos? Where:_____		
26.	Do you have any metal implants or hardware anywhere in your head or body? Where?:_____	☐	☐

HOW DID YOU HEAR ABOUT US? / REFERRED BY:_____

Signature: _____**Date:** _____

Provider Reviewed:_____ **Date:** _____