SOLE HEALTH

AESTHETIC MEDICAL HISTORY

Name: _____ DOB: _____

Do you have any of the following: **Mark yes or no and circle the answer.**

Yes / No Do you have any of these: Hypertension, Diabetes, High Cholesterol, Apnea?

Yes / No Have you ever had a blood clotting disorder, low platelets or platelet dysfunction?

Yes / No Heart stents, bypass or pacemaker, hearing aids?

Yes / No Myasthenia Gravis, Multiple Sclerosis, Amyotrophic Lateral Sclerosis (ALS), Parkinson's Disease?

Yes / No Autoimmune Disease, Lupus, Rheumatoid arthritis?

Yes / No History of Cold Sores ?

Yes / No Hepatitis B, HIV?

Yes / No Do you take blood thinners of ANY type? (coumadin, plavix, eliquis, xarelto, pradaxa, aspirin)?

Yes / No Do you take fish oil, flaxseed oil, St. John's Wort, Vitamin E, Ibuprofen, Advil, Naproxen?

Yes / No Have you ever had cancer of the face or neck? (including melanoma, squamous cell or basal cell cancers)

Yes / No Have you ever had Botox, filler or any facial surgery?

Yes/ No Allergies to lidocaine?

Yes / No Are you pregnant or nursing?

List and /or explain other medical conditions not listed above that you currently have or have had in the past:

_____

_____

SURGERIES/PROCEDURES_____

_____

LIST MEDICATION, CONTRACEPTIVES OR SUPPLEMENTS:(ANY ACCUTANE, HYDROQUINONE,GLYCOLIC ACID?)

_____

_____

ALLERGIES: _____

FAMILY HISTORY: _____

Patient Signature _____ Date_____