Medical/Health History

Name______________________________

DOB__________________

Please list all medications you are currently taking:

____
____
____
____
____
____

Medical conditions you have:

____
____
____
____

Allergies or allergic reactions(incl. latex):

____
____
____

Dental

Infections: **yes no**
Dental implants: **yes no**
TMJ (teeth clenching): **yes no**
Recent dental work? yes no
If yes, Date:______________

Are you taking antibiotics now? yes no

Face

Pain: **yes no**
Paralysis/weakness: **yes no**
Trauma/injury to area: **yes no**

Facial Surgeries: **yes no**
(if yes, list dates)____________________

Skin

COLD SORES EVER: yes no
Shingles: **yes no**
Hypertrophic/keloid scarring: **yes no**
Acne: **yes no**
Rosacea: **yes no**
MRSA (resistant staph infection): **yes no**

Hair

brittle or thinning: **yes no**

Eyes

Vision loss: **yes no**
Eyelid surgery: **yes no**

Other

Pregnant/nursing: **yes no**
Anaphylaxis: **yes no**
Metal Implants: **yes no**
(if yes, location)___________
Defibrillator: **yes no**
Pacemaker: **yes no**

1st visit only:

Have you had cosmetic injections before?
Yes____ No____
Were you happy with treatment?
Yes____ No____

Please initial:

_____I understand the information on this form is essential to determine my medical and cosmetic needs and the provision of treatment.

_____I have read and understand the above medical health 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 signature:

X______________________________

Date______________

~~~~~~~~For Practitioner Use Only~~~~~~~~

I have read the patient history and have determined that patient is cleared for treatment.

NP/DO/MD signature:

____
____

Date______________________

Notes:

____

By initialing and dating below, I agree that my medical health status has not changed since last year. I agree that should my medical/health change, I will inform Kiss Me Med Spa immediately.

Initials	Date	Physician Signature

My medical/health has change since my last visit, as listed below:

____
____
____
____
____
____
____
____
____
____
____
____
____
____

Patient Signature

X____

Date:_________________________

Practitioner Signature:

____

Date:___________________________