PHYSICIAN'S CENTER for Beauty™

Client Medical Inventory

Allergies

Drug Allergies (please list all):_____

_____

Sensitivity / Allergy to Latex? : No / Yes

Any Reactions to an Anesthetic: No / Yes if yes, describe: _____

_____

Current Medications

Name: _____ Dose: _____ Frequency: _____ Reason: _____

Name: _____ Dose: _____ Frequency: _____ Reason: _____

Name: _____ Dose: _____ Frequency: _____ Reason: _____

Name: _____ Dose: _____ Frequency: _____ Reason: _____

Name: _____ Dose: _____ Frequency: _____ Reason: _____

Name: _____ Dose: _____ Frequency: _____ Reason: _____

Name: _____ Dose: _____ Frequency: _____ Reason: _____

Name: _____ Dose: _____ Frequency: _____ Reason: _____

Additional (List): _____

Over the Counter Medications: Aspirin Ibuprofen (please circle, if taken)

Do you take ANY herbal or natural supplements? No / Yes, if yes, please describe_____

_____

Birth Control Pills: No / Yes if yes, name: _____
Are you pregnant? No / Yes

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Social History

Alcohol Intake: Never Rarely Socially Daily

Tobacco Use: No / Yes if yes, how many packs / day? _____For How Long? ____ years

Current Medical Conditions

(Please Circle All Conditions Which Apply To You)

Bleeding / Bruising / Clotting Disorders if yes, describe: _____
Endocrine Disorders: Thyroid -- Over / Under Active
Seizure Disorder Heart Disease Heart Pacemaker Blood Vessel Disease
High Blood Pressure Kidney Disease Arthritis
Autoimmune Disorders – Lupus / Rheumatoid Arthritis / Others
Muscle Weakness / Disorders Myasthenia Gravis Diabetes Asthma

Others (describe): _____

Past Medical History

Surgical / Procedure History:

Please list any procedures in the past six months: _____

_____

Please list any prior cosmetic surgery: _____

_____

Primary Health Provider: _____

Pharmacy: _____ Phone / Email: _____

Skin / Aesthetic History

Current Skin Care Regimen

Wash Face with _____

Moisturizer _____

Any other products _____

Any Active Skin Infections / Conditions? No / Yes if yes, describe: _____

_____

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Current or Past Fever Blisters / Cold Sores / Herpes? No / Yes if yes, describe: _____

_____

History of Excessive Scarring / Keloid Formation / Poor Wound Healing After Surgery?

No / Yes , if yes, describe: _____

_____

Personal history of skin cancer? No / Yes if yes, describe: _____

_____

Exposure to Retinoids:
Prior Oral Intake of isotretinoin (Accutane)? No / Yes When last? _____
Topical retinoids – tretinoin / adapalene / tazarotene? No / Yes
If yes, how often, and when last? _____

Prior Microdermabrasion / Dermabrasion? No / Yes If yes, please describe: _____

_____

Prior Chemical Peels? No / Yes if yes, please describe: _____

_____

Prior Treatments for Wrinkles?
Botox? No / Yes if yes, when last, and how often? _____
Dermal Fillers? No / Yes
Restylane/Perlane? No / Yes if yes, describe: _____

Juvederm? No / Yes if yes, describe: _____

Radiesse? No / Yes if yes, describe: _____

Other? No / Yes if yes, describe: _____

Any problems with wrinkle treatments? No / Yes if yes, describe: _____

_____

History of exposure to radiation treatments? No / Yes if yes, describe: _____

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History of Skin Rash / Hives? No / Yes if yes, describe: _____

Have you any permanent make-up, implants, or tattoos? No / Yes if yes, describe: _____

Prior Injections with Gold? No / Yes if yes, please describe: _____

Have you any recent use of tanning creams? No / Yes if yes, describe: _____

How often do you sunbathe? (circle the best answer) Last Tan: _____

Never
Sometimes ≤10 days / year
Regularly ≥11 + days / year

Have you attended a tanning bed / salon in last 90 days? No / Yes if yes, when last and how often? _____

Permission for Photography

I give permission for the Physician's Center for Beauty to take photographs of me before, during, and after my treatments. As the condition creates a visual image, this image is important in the diagnosis and management of my concerns. These photographs will be an important part of my medical record. These photographs may be used (with identity protected) for research purposes and educational purposes, and may be published in professional medical journals or books.

Signature: _____

Date: _____
(mm/dd/yyyy)