**PUR AESTHETICS**

**CLIENT PROFILE AND MEDICAL HISTORY FORM**

Today’s Date:\_\_\_\_\_\_\_\_\_\_\_\_

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Sex:\_\_\_\_\_\_\_\_Age:\_\_\_\_\_\_\_\_DOB:\_\_\_\_\_\_\_\_

Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Daytime Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_

City:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_State:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Zip code:\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cell/Alt Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How did you hear of us:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Would you like to receive promotional mail or newsletter? Information on events and

upcoming promotions will be sent when relevant. Please check yes or no, also please check if

you would like it sent via mail or email.

Yes\_\_\_\_\_\_\_\_\_\_\_\_NO\_\_\_\_\_\_\_\_\_

Email:\_\_\_\_\_\_\_\_\_Mail:\_\_\_\_\_\_\_\_

1. Have you ever had or have been treated for: please circle any illness/disease that

pertains to your health:

AIDS/ARC Drug/alcohol addiction Diabetes Mitral Valve Problems

Allergy/Hay Fever Dizziness/fainting spells Neuritis

Anemia Epilepsy Nervousness

Asthma/ Wheezing or Shortness of Breath Eye Injury or disease Phlebitis of veins

Ankle or Feet Swelling Fever Rheumatism/arthritis

Autoimmune Disease Frequent/severe Headaches Skin rash/disease

Back Problems/Pain Head Injury Tendonitis

Bleeding Problems or Disorders Heart Trouble Tuberculosis

Cancer: Type:\_\_\_\_\_\_\_\_\_\_\_\_\_ High blood pressure Varicose Veins

Joint Pain/swollen joints

2. List any other diseases or illnesses you have had:

3. List all prescription and non-prescription medication you are currently taking or have

recently taken:

4. Do you drink alcohol: No Yes Do you smoke? No Yes

1-2 drinks per week

3-5 drinks per week

5+ drinks per week

5. Family physician: (name and telephone number):

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Pharmacy phone #:

6. When you go to the dentist:

Do they give you antibiotics before a procedure: Yes No

Do you require extra numbing medication: Yes No

7. Allergies: List all allergies:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you allergic/sensitive to (Circle all that apply):

Lidocaine Latex Hydroquinone Aspirin Milk

8. Have you had any previous cosmetic procedures:

Describe:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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9. WOMEN ONLY: Date of last menstrual period\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you pregnant?\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Due date:\_\_\_\_\_\_\_\_\_\_\_\_

10. Do you wear contacts?\_\_\_\_\_\_\_\_\_\_\_\_

11. Skin Description: Tell me about your skin, describe it for me: Do you consider

yourself:

Sensitive Resilient Not sure

Do you “Flush” or appear to redden easily when you eat spicy food, drink alcohol, Get

angry, go in the sun ETC?:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

12. Pigmentation (FITZPATRICK SCALE): How do you tan?

I Burn II Usually Burn III Sometimes IV Rarely Burn V Never Burn

VI Never Burn (Dark skin tones)

Pigmentation: Even Uneven

13. Ability to heal: Do you have any problems healing from a cut or a burn: Yes or No

Have you ever had a cold sore? Yes or No

14. Sun History Do you work inside: \_\_\_\_\_\_\_\_Are your hobbies done mostly

outside?\_\_\_\_\_\_\_\_ Do you go to tanning beds? \_\_\_\_\_\_\_\_\_\_Have your ever used a

tanning bed?\_\_\_\_\_\_ Do you currently use sun block regularly?\_\_\_\_\_\_\_\_\_ Have you or

anyone in your family had skin cancer? \_\_\_\_\_\_\_\_\_If yes, explain:

15. Desired improvements: What specific areas do you want to

treat?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What are the cosmetic improvements you would like to see in your skin appearance?

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**Patient Signature** **Date**

**Registered Nurse/ or Nurse Practitioner-(Medical Director) Date**

**Certified Aesthetic Injector Signature**