DR. VICK'S LA MEDICAL SPA

PATIENT HISTORY

First Name: _____ Last Name: _____ Date: _____

Address _____ City& State _____ Zip: _____

_____ _____

Home Ph: _____ Cell: _____ Office: _____

Referred by: _____ or, How did you hear about us? _____

Family Physician: _____ Date of Birth: _____

Address: _____ Email Address: _____

_____ Occupation:

Y	N	Do we need to be discrete with messages?
Y	N	Can we contact you by email?
Y	N	Female patients: Are you or could you be pregnant or nursing>? Are you trying to get pregnant?
Y	N	Do you experience easy or excessive bleeding or bruising?
Y	N	Have you ever had a bad reaction to any type of anesthetic or dental anesthesia?
Y	N	Have you had any eye problems or eye surgery?
Y	N	Do you or any family members have any neurological disorders such as myasthenia gravis or Eaton Lambert Syndrome or ALS (Lou Gehrig's Disease)
Y	N	Have you used Retinoids (Retin A, Renova, Tretinoin, Adapalene?
Y	N	Have you ever used accutane (isotretinoin)?
Y	N	Have you had chemical peels?
Y	N	Have you had laser therapy?
Y	N	Have you had collagen diseases (Lupus, scleroderma, etc.)?
Y	N	Do you scar easily or excessively? Do you have any keloids?
Y	N	Have you sun bathed or visited/used a tanning bed in the past month?
Y	N	Have you used tanning lotion in the past 2 weeks?
Y	N	Do you have any active infection?
Y	N	Have you had any cosmetic surgery? If so, type and date of surgery:
Y	N	Have you been treated in the past with filler agents? Restylane, Perlane, Juvederm, etc. or Botox/Dysport? If so what agents and when?
Y	N	Have you ever had problems with any cosmetic procedures (Fillers, Botox, Peels, Microdermabrasion, and Laser Treatment Surgeries)?
Y	N	Do you smoke?
Y	N	Do you drink alcohol in excess?
Y	N	Have you recently taken aspirin, nasaids, vitamin E, Ginko, St. John's Wart, Blood Thinners (Coumadin/Plavix, etc)

Please circle any existing conditions:

Cancer
Diabetes
Glaucoma
Artificial Valve, Joint Prosthesis
Tuberculosis
Asthma
Thyroid Disease
Migraines/headaches
Skin Sensitivities (sun/other)
Addictions/Alcoholism
Arthritis
Autoimmune disease
Hirsutism (excessive hair growth)
Heart Murmur
Congenital Heart Defect
Cardiac Pacemaker
Heart Trouble/Angina
HIV/AIDS
Sickle Cell Disease
Blood Transfusions
High Blood Pressure
Seizures/Epilepsy
Blood Disorders/bleeding/clotting
Metal Implants (Including IUD)
Prior Accutane (isoretinoin) use
Milk Product Allergy
Hepatitis/Liver Disease
Anemia
Keloids (excessive scaring)
Emphysema
Recent Dental procedure
Warts
Skin Conditions
Rosacea
Fainting Spells
Sinus Trouble
Kidney Disease
Psychiatric Treatment
Cold Sores (Herpes)

How do you prefer we contact you for future appointments? Please Circle

1. **Phone Call**
2. **Email**
3. **Text Message**

Are you allergic to any medications? Please circle, YES or NO. If yes, please list here.

1.

2.

3.

Please list all medications you are currently taking, including non-prescription items.

1.

2.

3.

Please list any other condition you have or have had that have not been noted on this patient history:

1.

2.

3.

List all prior surgical procedures:

1.

2.

3.

I, _____, certify that I understand the above and have answered all the questions truthfully.

Signature: _____ Witness: _____

Photographs:
I authorize the taking of clinical photographs and their use for in office use only. YES or NO

I authorize the taking of clinical photographs and their use for scientific purposes in publication and presentations. I understand my identity will be protected. YES or NO

Patient Signature: _____ Date: _____
Clinician Signature: _____ Date: _____