

# WESTSIDE AESTHETICS

## Medical History

Date: \_\_\_\_\_

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_

Address: \_\_\_\_\_ Suite/Apt. No. \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Cell Phone: \_\_\_\_\_ Home Phone: \_\_\_\_\_ Work: \_\_\_\_\_

E-Mail: \_\_\_\_\_

Best way to contact you is: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Sex: Male Female

Family Doctor: \_\_\_\_\_ Doctor Phone No: \_\_\_\_\_

Pharmacy: \_\_\_\_\_ Pharmacy Phone No: \_\_\_\_\_

### Please answer all of the following questions:

How did you hear about us? \_\_\_\_\_

If you were referred by one of our patients, please share his/her name so we may thank them: \_\_\_\_\_

Do you have ANY current or chronic medical illness, specifically: Myasthenia Gravis, Amyotropic Lateral Sclerosis, or any other Neuromuscular disorders? YES NO Please list: \_\_\_\_\_

Are you currently under a doctor's care? YES NO If so, for what reason? \_\_\_\_\_

Do you take/use ANY medications, herbal/natural supplements or topicals on a regular or daily basis? YES NO  
Please List: \_\_\_\_\_

Do you have ANY allergies to medications, food, latex, or other substances? YES NO  
Please list: \_\_\_\_\_

**For Women** -Are you or could you be pregnant? YES NO  
-Are you breast feeding? YES NO  
-Are your menstrual periods regular? YES NO

Have you had cold sore breakouts (oral herpes) in the past year? YES NO

Do you have history of Keloid Scarring? YES NO

Have you taken Retin-A, Anticoagulants, or Accutane in the last year? YES NO

Have you ever had surgery? YES NO

If so, when and what area? \_\_\_\_\_

Have you previously received BOTOX injections before? YES NO

When \_\_\_\_\_ Area treated: \_\_\_\_\_ Dosage Amount: \_\_\_\_\_

**WESTSIDE AESTHETICS DOES NOT GIVE REFUNDS ON ANY PRODUCTS OR SERVICES RENDERED.**

**I HAVE READ AND UNDERSTAND THE ABOVE QUESTIONS. BY SIGNING THIS DOCUMENT I AGREE THAT THE INFORMATION CONTAINED HEREIN IS TRUE TO THE BEST OF MY KNOWLEDGE.**

SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_