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:** _____