Aesthetic Client Intake Form

Date: _____

First Name: _____ **Last Name:** _____

D.O.B. _____ **Male** ☐ **Female** ☐

Medical History

Please select if you have following conditions:

☐ Bleeding disorder	☐Clotting disorder	☐Keloid scars
☐Connective tissue disorder	☐Myasthenia gravis	☐ALS
☐Lambert-Eaton syndrome	☐Parkinson's disease	☐ Autoimmune disease Specify _____
☐Recent Dental Procedure (2 weeks)	☐Cold sore/herpes Where_____	☐Skin Cancer
☐Pregnant	☐Breastfeeding	☐Diabetes
Other medical conditions:		

Current Medications:_____

Allergies: _____

List any facial or dental surgeries in the past and when:

_____

List any aesthetic/cosmetic procedures you have had in the past and when:

_____

Past adverse reactions to cosmetic injections or treatments

_____

List aesthetic treatment you are interested in:

Fillers ☐ **Area**_____

Botox ☐ **Area**_____

Mesotherapy ☐

Fat Dissolving treatment ☐ **Area**_____

Others _____

Signature: _____