Today's Date:
Dates Revised: (Office Use)

ALLURE REJUVENATION CENTER
HISTORY & PHYSICAL FORM

All questions contained in this questionnaire are strictly confidential
and will become part of your medical record.

Name *(Last, First, M.I.):*		☐ M ☐ F	**DOB:**
Address:			
Phone:	**Mobile:**	**Email:**	
Preferred Method of Contact: **Phone:** ☐	**Mobile:** ☐	**Email:** ☐	
Is it okay to leave a message on your voicemail?	**Yes** ☐	**No** ☐	
Occupation:			
How did you hear about us?			
Reason for today's visit?			

REASON FOR VISIT

Please indicate any concerns		
Wrinkles ☐	**Botox** ☐	**Fillers** ☐
Skin Care ☐	**Chemical Peels** ☐	**Latisse** ☐
Dark Spots ☐	**Redness / Rosacea** ☐	**Lasers** ☐
Other (please explain):		

PERSONAL HEALTH HISTORY

List any medical problems that other doctors have diagnosed

Surgeries

Year	Reason	Hospital

Please turn to next page

List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers and herbal supplements		
Name the Drug	Strength	Frequency Taken
Allergies to medications & food		
Name the Drug or Food	Reaction You Had	

Do you take any blood thinning medications, including but not limited to, Aleve, ibuprofen, aspirin, vitamin E, fish oil, Coumadin?		
Name the Medication	Strength	Frequency Taken

Do you take any muscle relaxants?		
Name the Medication	Strength	Frequency Taken

Any difficulty swallowing?	☐ Yes	☐ No
Are you planning to have LASIK eye surgery?	☐ Yes	☐ No
Do you use sunscreen?	☐ Yes	☐ No
Are you pregnant, nursing or have any plans of getting pregnant?	☐ Yes	☐ No
Have you had any of the following antibiotics within the past month?		
Gentamicin ☐	Tobramycin ☐	Aminoglycoside ☐

Please turn to next page

HEALTH HABITS AND PERSONAL SAFETY

Do you drink alcohol?	☐ Yes	☐ No
When was your last alcoholic beverage?		
Do you smoke?	☐ Yes	☐ No

PAST PERSONAL MEDICAL HISTORY

PLEASE SELECT ALL THAT APPLY

Skin Cancer ☐	**Acne** ☐	**Warts** ☐
Herpes (HSV) / Cold Sores ☐	**Shingles (HZV)** ☐	**Scars / Keloids** ☐
Fungal Infections ☐	**Hives** ☐	**Psoriasis / Eczema** ☐
Glaucoma/Cataracts or any other eye Conditions ☐	**Ear, Nose & Throat Conditions** ☐	**Seizures / Fainting** ☐
Bleeding Disorders ☐	**High Blood Pressure** ☐	**Diabetes** ☐
HIV / AIDS ☐	**Gastrointestinal Conditions** ☐	**Chemotherapy** ☐
Cancer ☐	**Myasthenia Gravis** ☐	**Guillain-Barre** ☐
Multiple Sclerosis ☐	**Lambert-Eaton Syndrome** ☐	**Vision Problems** ☐
Autoimmune Disease ☐	**Muscle Weakness** ☐	**Parkinson's** ☐
ALS (Lou Gehrig's Disease) ☐	**Other Neurological Disorders** ☐	**Allergies to Egg / Albumin** ☐
Allergies to Milk Products ☐	**Seasonal Allergies** ☐	

FAMILY HEALTH HISTORY

	AGE	SIGNIFICANT HEALTH PROBLEMS
Father		
Mother		
Sibling		

OTHER PROBLEMS

Check if you have, or have had, any symptoms in the following areas to a significant degree and briefly explain.

☐ Skin	☐ Chest/Heart
☐ Head/Neck	☐ Back
☐ Ears	☐ Intestinal
☐ Nose	☐ Circulation
☐ Throat	☐ Other pain/discomfort:
☐ Lungs	

Please turn to next page

PAST TREATMENTS

Have you had Botox / Dysport / Xeomin infections before?	☐ Yes	☐ No
When was your last treatment?		
Which areas have you had treated with Botox?		
Have you had any side effects from Botox?	☐ Yes	☐ No
Have you experienced ptosis (eyelid or eyebrow droop) after Botox treatment?	☐ Yes	☐ No
Do you easily bruise from injections?	☐ Yes	☐ No
Have you had any chemical peels?	☐ Yes	☐ No
When was your last chemical peel?		
Do you know the name of the chemical peel?		
Did you have any side effects from the chemical peels?		
Have you tried Latisse before?	☐ Yes	☐ No
Any side effects from Latisse?	☐ Yes	☐ No
If yes, please describe the side effects:		
What skin products are you currently using?		
Are you using retinol product (i.e. Retin-a?	☐ Yes	☐ No
Have you used Accutane?	☐ Yes	☐ No
When were you last treated?		

I certify that the answers listed above are true and correct. I am aware that it is my responsibility to inform the staff of Allure Rejuvenation Center of my current medical and health conditions and to update my history with any changes that may occur.

Print name: ______________________________

Signature: ______________________________

Date: ______________________________