Wellness by the Sea

35998 Zion Church Road, Unit 1, Frankford, DE 19945 - 302-278-0093 (phone) - 302-278-0096 (fax)

AESTHETIC PATIENT HISTORY

Name: _____ Date: _____

Street Address: _____

City, State, Zip Code: _____

Mobile Phone: _____ Email: _____

Consent to email and test message notifications: _____ Yes _____ No

Emergency Contact/Phone: _____ _____

Date of Birth: _____

Medications:

Immune Suppressants	Yes	No	If yes, name: _____
Anticoagulants	Yes	No	If yes, name: _____
Antibiotics	Yes	No	If yes, name: _____
Steroids	Yes	No	If yes, name: _____
Anti-Inflammatories	Yes	No	If yes, name: _____
Non-Steroidal Anti-Inflammatories	Yes	No	If yes, name: _____

(Ex: aspirin, motrin, advil, aleve, ibuprofen, naproxen sodium, aspirin, voltaren, diclofenac, celebrex, Indocin, meloxicam – most common)

Other Medications: _____

Supplements: (circle all)

Ginko Biloba Vitamin A Vitamin E Flax Oil Fish Oil Garlic

Other: _____

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Present and Past Medical History:

___ Multiple Severe Allergies ___ Anaphylactic Shock ___ Asthma

___ Diabetes ___ Hypertension ___ Cardiac Disease

___ Cardiac Arrhythmia ___ Excessive Bleeding ___ Bleeding Disorder

___ Liver Disease ___ Transplant (Any) ___ Mental Disease

___ Neuromuscular or Peripheral Disorders ___ Dysphagia

___ Other _____

Present and Past Skin History:

___ Eczema Treatment: _____

___ Psoriasis Treatment: _____

___ Rosacea Treatment: _____

___ Acne Treatment: _____

___ Melasma Treatment: _____

Are you pregnant? Yes No

Are you breast feeding? Yes No

Do you smoke? Yes No

Do you consume Alcohol Yes No # Drinks/week _____

Recent Skin Treatments:

Laser Therapies	Yes	No	Date: _____
Skin Peels	Yes	No	Date: _____
Cosmetic Surgeries	Yes	No	Date: _____
Botox	Yes	No	Date: _____
Dermal Fillers	Yes	No	Date: _____
PDO Threading	Yes	No	Date: _____

Previous complications for any skin treatments listed above or others: _____

_____

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Current Skin Care Regimen: _____

_____

The information listed above is true and accurate to the best of my knowledge. I understand

I will provided treatment based upon the medical history I have provided.

_____	_____	_____
Signature	Printed Name	Date

I give permission and understand that photographs will be taken of all sites treated which will be used to document my medical record. I also understand these photos will be used internally for medical persons only and will be maintained in my medical record.

_____	_____	_____
Signature	Printed Name	Date