SUGARLAND MEDICAL & AESTHETICS

MEDICAL HISTORY FORM

Last Name:	First Name:	
Address:		
City:	State:	Zip Code:
Date of Birth:	Cell:	Email Address:
Family Doctor:	Phone:	
Pharmacy:	Phone:	
Emergency Contact:	Phone:	

Please answer the following questions.

1. Do you have ANY current or chromin medical illnesses we should know about? ☐ YES ☐ NO

Please List:

2. Are you currently under a doctor's care? ☐ YES ☐ NO

If so, for what reason?

3. Do you take/use any medications, herbal, or natural supplements or topicals on a regular or daily basis? ☐ YES ☐ NO

Please List:

4. Do you have ANY allergies to medications, foods, latex or other substances? ☐ YES ☐ NO

Please List:

Medical History

5. (For Women) are you or could you be pregnant? ☐ YES ☐ NO
6. (For Women) are your menstrual periods regular? ☐ YES ☐ NO
7. Do you have a history of herpes 1 or 11 in the area to be treated? ☐ YES ☐ NO
8. Do you have a history of keloid scarring? ☐ YES ☐ NO

MEDICAL HISTORY FORM

9. Have you taken Accutane or Anticoagulants in the last 6 months?	YES	NO
10. Do you have any permanent make-up, implants or tattoos?	YES	NO
If yes, please list locations:		
11. Have you had any unprotected sun exposure, used tanning creams or tanning beds in the last 4 – 6 weeks?	YES	NO
12. Which body area / areas or condition would you like to be treated?	YES	NO

Signature:	Date: