PATIENT INFORMATION & MEDICAL HISTORY

In order to provide you with the most appropriate treatment, we need you to complete the following questionnaire. All information is strictly confidential.

PERSONAL INFORMATION

Name____Date________________

DOB______________Age _________Occupation______________________________

Home Address ____

City_____________State_____Zip _________

Home Phone________________Cell Phone ________________Email_______________________

What is the best number for you to receive a follow up call? _______________________

Emergency Contact Name & Phone ____

How were you referred to us?

- ○ Location
- ○ Google
- ○ Billboard
- ○ Facebook / Instagram
- ○ Other _______________
- ○ Referred by Friend/Family _______________

Are you a New Patient to Goldfingers Aesthetics & Plastic Surgery? YES / NO

Alle Loyalty Program/ASPIRE REWARDS
Are you currently enrolled in the Alle Program? YES / NO
Are you currently enrolled in the Aspire Rewards? YES / NO
Please list if you have a gift card to apply to today's puchase
$____________________

If not, Alle/Aspire are programs that reward you with savings on facial treatments & products, like Botox, Restylane, Juvederm & SkinMedica.

MEDICAL HISTORY

NAME: ______________________________________DATE: ______________

Are you currently under the care of a physician? YES / NO

If yes, for what?____

Do you have any of the following medical conditions? (Please mark YES or NO to all)

PLEASE CHECK ALL THAT APPLY:	YES	NO		YES	NO
Cancer			Diabetes		
High Blood Pressure			Herpes Sinplex (Cold Sore)		
Arthritis			Frequent cold sores		
HIV/AIDS			Keloid scarring		
Skin disease			Skin Lesions		
Seizure Disorder			Hepatitis		
Hormone Imbalance			Thyroid Imbalance		
Blood Clotting Abnormalities			Any active infection		
Heart Conditions			Chest Pain		
Are you pregnant or trying to get pregnant?			Are you breastfeeding?		
Are you using contraception?			Birth control pills		
NEUROLOGIC DISEASES:			Parkinson's		
Myasthenia Graves			Multiple Sclerosis (MS)		
Lambert-Eaton Syndrome			Amuotrophic Lateral Sclerosis (ALS)		

What prescriptions medications are you taking? List: ____________________________________

Are you taking any antibiotics ? Please List: ____

Are you presently taking any of the following medication or supplements listed below?

	YES	NO		YES	NO		YES	NO
Aspirin			Blood thinners			Hormones		
Mood altering medication			Anti-depression medication			Vitamin E		
Fish Oil			Omega 3 fatty acids			Ginkgo biloba		
Garlic			Ginger			Cayenne		
Licorice			Flax seed oil			COQ10		

Have you ever had an allergic reaction to the following?

☐Food ☐Animal Protein ☐Aspirin ☐Lidocaine ☐Hydrocortisone ☐Eggs

☐Latex ☐Hydroquinone or skin bleaching agents

Others: ____

FACIAL HISTORY

1) What areas of concerns would you like to address? ________________________________

2) What are your expectations for today's visit? ____

What topical medications or creams are you currently using? ☐Retinol ☐Other

(List):____

Please let the provider know if you have had any facial services within 7 days ie: chemical peel, microneedling, laser ____

Have you ever had Botox/Dysport? YES / NO If yes, date: ___________________

Have you ever had Fillers? YES / NO

If yes, what type of fillers used ____________________________

Any complications? YES / NO If yes, please specify: ____

I certify that the preceding medical, medication and personal history statements are true and correct. I am aware that it is my responsibility to inform the doctor or other health professional of my current medical health conditions and to update this history. A current medical history is essential for the caregiver to execute appropriate treatment procedures.

Patient Name (Print) _______________________

Patient Signature___________________________Date: ________________