GOLDFINGERS AESTHETICS
& PLASTIC SURGERY

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: _____