Solutions medical center
aesthetics, wellness & weight loss

Personal Profile and Health History Form

Date__________
Name______________________________________ **Gender** M F **Age**_______ **Date of Birth**__________________
Address____________________________________ **City**____________________**State**__________ **Zip**____________
Home Phone_____________________**Work Phone**_______________________**Cell Phone**______________________
Email Adress____
How did you hear about our clinic?____

Specify your genetic origin:

- African American
- Asian
- Caucasian
- Hispanic
- Mediterranean
- Middle Eastern
- Native American
- Other____________

For Females:

- Are you pregnant? Y N
- Are you breastfeeding? Y N
- Do you have regular periods? Y N
- Are you going through menopause? Y N
- Have you already been through menopause? Y N

Please list all medications you are currently taking including prescription, over the counter, vitamins, herbs and supplements:

________________________ ________________________
________________________ ________________________
________________________ ________________________
________________________ ________________________

Please list all medications you are allergic to and the reaction you had:

________________________ ________________________
________________________ ________________________
________________________ ________________________
________________________ ________________________

Past Medical History: (check all that apply)

__Acne
__Bleeding Disorders
__Botox (last injection_______)
__Burns/Skin Grafts
__Cancer of any type
__Dermal Fillers (last injection______)
__Endocrine Disorders (Diabetes, etc)
__Gout
__Heart Disease
__Herpes (type 1 or 2)
__High Blood Pressure
__Hirsutisim (excessive hair)
__Hormone Replacement
__Implants
__Keloid Scars
__Lupus
__Migraine Headaches
__Neurological Disorders
__Neuromuscular Disorders
__Psoriasis
__Rosacea
__Seizures
__Shingles
__Skin Cancer
__Tattoos
__Thyroid Disorders
Other________________________

Please answer the following questions:

1. Are you currently being treated for any medical conditions? **Yes No** If so, please list___________________________
2. Do you smoke? **Yes No** If so, how many packs per day?____
3. Are you allergic to Latex, Lidocaine, any lotions or gels? **Yes No**
4. Are you or have you ever been on Accutane? **Yes No** If so, when?____
5. Have you had any surgeries or hospitalizations in the past 3 years? **Yes No** If so, please list why_________________
6. List any laser treatments that you have had?____
7. Please list any of our services that you are interested in:

____________________________ __________________________
____________________________ __________________________
____________________________ __________________________
____________________________ __________________________

I confirm that the answers to the questionnaire are true and correct.

Patient Signature____ Date____________________________
Signature of Provider_______________________________________ Date____________________________