Date: _____

Personal History

Name:_____ Age_____ Date of Birth:_____Gender: F M

What services you are interested in?

□ Skin Care □ Fillers □ Body Contouring
□ Botox □ Thread Lift □ Micro-needling
□ Other □ Laser Resurfacing □ Specific Skin Concerns
List:_____ List:_____

Have you had any previous cosmetic procedures? If yes, please check the appropriate box.

□ Facials/Peels □ Waxing □ Thread Lift □ Microdermabrasion □ Dermaplaning
□ Photofacials □ Botox □ Chemical Peels □ Micro-needling □ Laser Hair Removal
□ Skin Lighteners □ Fillers □ Retinols □ CO2 Laser Resurfacing □ Surgery
Other:_____

Please list all products you are currently using on your skin (soaps, prescription topical, creams, scrubs, etc.)

_____

_____

My skin type is:

□ Normal □ Oily □ Dry/Dehydrated □ Combination □ Acne/Acne prone □Rosacea

Have you used Accutane (isotretinoin) in the past?_____If so, when?_____

Do you currently have or have a history of any of the following conditions?

Cancer	Yes	No	Melasma	Yes	No	Myesthenia Gravis	Yes	No
Diabetes	Yes	No	Psoriasis	Yes	No	Blood Disorder	Yes	No
Rosacea	Yes	No	Eczema	Yes	No	Skin rash/disease	Yes	No
Bells Palsy	Yes	No	Keloid scaring	Yes	No	Lambert- Eaton Synd	Yes	No
Anemia	Yes	No	Migraines	Yes	No	Herpes/Cold Sores	Yes	No
Acne	Yes	No	HIV/AIDs	Yes	No	Multiple Sclerosis	Yes	No
Seizures	Yes	No	Palpitations	Yes	No	Mental Disorder(s)	Yes	No
Liver Disease	Yes	No	Very dry skin	Yes	No	Leber's Disease	Yes	No
Nursing	Yes	No	Pregnant/planning pregnancy	Yes	No			

Other Current Medical Conditions:_____

Current Prescriptions, Over-the-counter Medications & Supplements (name, dose):_____

_____

_____

Drug Allergies:_____

Allergies/Sensitivities (food, seasonal):_____

_____

Latex Allergy: Yes No Novicaine or Lidocaine Allergy: Yes No

History of anaphylactic reaction(s): Yes No

Patient Agreement

Dr. Wendy Dickerson strives to provide the best treatments and highest quality of professional service in an on-time manner. If you are unable to keep the appointment that you scheduled, we ask that you respectfully cancel the appointment within 24 hours. We realize that your time is valuable and hope you will extend the same courtesy to our physicians. We confirm appointments by email. We reserve the right to to assess a $45 charge for missed appointments.

I understand the above policy and agree to comply. By signing, I attest that all the above patient information is true and accurate to the best of my ability.

Name:_____ Date:_____

Signature:_____

Practitioner;_____ Date:_____