A picture containing text, blackboard, sign

Description automatically generated

Patient Health History Intake Form Date

Name Male/ Female

Address

City , State

Cell Email

Zip

Birthdate , Emergency Contact Phone

Emergency Contact Relationship

How did you hear about us? Google Facebook Instagram Family Member Friend

Staff member at Glow Aesthetics LinkedIN Advertisement Other

Demographics: Married Divorced Single Separated Widowed Occupation:

Please check any and all the medications you are currently taking and/or have taken in the last two weeks from the below list:

Aspirin Advil Motrin Ibuprofen

Aleve Naprosyn Excedrin Coumadin

Warfarin Plavix Lovenox Accutane

Others

Please check any and all supplements and topical serums, oils, or creams in the last two weeks:

Vitamin E Vitamin A RetinA Renova

Tretinoin Differin Triluma Gingko Biloba

Omega-3 fatty acids Cod liver oil CoQ10 Garlic/ Ginger

Others

List all allergies to medications and to foods such as eggs, egg products, and Albumin:

|  |  |  |
| --- | --- | --- |
| *Please answer the below questions:* |  |  |
| Alcohol Use? Daily Weekly Social Rarely Never |  |
| Are you pregnant? | Y/N |
| Are you breast feeding? | Y/N |
| Have you ever had Botox®? | Y/N | Last treatment date |
| Have you ever had filler treatment? | Y/N | Last treatment date |
| Glow Aesthetics and Wellness Studio, LLC [www.glowaestheticsandwellnessstudio.com](http://www.glowaestheticsandwellnessstudio.com/) | | |

Have you ever had a negative response to injection treatments? Y/N If yes, what happened?

Do you have a special event in the next week? Y/N

How is your pain tolerance to injections? 1 2 3 4 5 1 being low, 5 being high Do you have a defibrillator? Y/ N

Do you have a pacemaker? Y/ N

Inoculations:

Have you been vaccinated within the last 30 days? Y/N If yes, what was the date of your last injection?

Which vaccine did you have?

Did you have more than one injection? Y/N If yes, what are the dates of both injections? What brand of vaccine did you receive?

Any negative reactions to the vaccine? Y/N High temperature? Y/N

Loss of taste/ smell? Y/N

Flu feeling? Y/N

Tested positive for Covid after injection(s)? Y/N Blood clotting? Y/N

Stroke? Y/N

Heart issues? Y/N

Hyper Inflammation Reaction to current fillers? Y/N Your Medical History and Your Family History:

List the medical conditions you have had as well as your family members who has had or does have the medical condition(s) below:

*Mother, Father, Son, Daughter, Brother, Sister, Maternal Grandparent, Paternal Grandparent*

(Do **not** include Aunts, Uncles, Cousins, or any distant relatives)

|  |  |  |  |
| --- | --- | --- | --- |
| Medical Condition | Your History | Family History | Who in family? |
| Allergies | Y/N | Y/N |  |
| Arthritis | Y/N | Y/N |  |
| Asthma | Y/N | Y/N |  |
| Autoimmune Disease | Y/N | Y/N |  |
| Bleeding Disorders | Y/N | Y/N |  |
| Blood Clots | Y/N | Y/N |  |
| Cancer | Y/N | Y/N |  |
| Chronic Sinusitis | Y/N | Y/N |  |
| Diabetes | Y/N | Y/N |  |
| Heart Disease | Y/N | Y/N |  |
| Herpes/ Cold Sores | Y/N | Y/N |  |
| High Blood Pressure | Y/N | Y/N |  |
| HIV/ AIDS | Y/N | Y/N |  |

|  |  |  |  |
| --- | --- | --- | --- |
| Melanoma | Y/N | Y/N |  |
| Migraine Headaches | Y/N | Y/N |  |
| Neurological Disease | Y/N | Y/N |  |
| Repeated Infections | Y/N | Y/N |  |
| Seizures | Y/N | Y/N |  |
| Skin Cancer | Y/N | Y/N |  |
| Thyroid trouble | Y/N | Y/N |  |
| Tuberculosis | Y/N | Y/N |  |
| **Personal Medical Condition:**  Height | Weight |  |  |

Hospitalization History

Last Time in Hospital Date

Name of Hospital

What was the reason for your hospitalization?

Surgery History

Last time you had surgery

What was the surgery for?

Where was the surgery?

Have you had plastic surgery before? Y/N If so, when?

What did you have done?

I certify that the above information is correct to the best of my knowledge. This information is only for clinic use and will not be shared with others.

Signature , Date

RN Signature , Date

NP/MD Signature , Date