ULTIMATE BEAUTY, HEALTH & WELLNESS
Cosmetic Medical History Form

Last Name:_____ First Name:_____ Sex:_____
Address:_____
City:_____ State:_____ Zip Code: _____Date of Birth:_____
Telephone Home:_____ Work:_____ Cell:_____
Occupation:_____
Which of your numbers may we leave a detailed message at? Please circle: work, home, cell, none
Email (to receive monthly specials/newsletter/promotions):_____
Emergency Contact:_____ Phone:_____ Relation:_____

Please answer all of the following questions:
1. Do you have ANY current or chronic medical illness? Yes No
Please list:_____
2. Do you take ANY medications, vitamins, supplements, topical treatments? Yes No
Please list:_____
3. Do you have ANY allergies to medications, foods, latex, or other substances? Yes No
Please list:_____
4. Do you have a history of cold sores/ herpes I or II in the area being treated? Yes No
5. Do you have a history of keloid scarring? Yes No
6. Have you had unprotected sun exposure, used tanning creams or beds in the last 4-6 weeks? Yes No
7. Do you have permanent make up or tattoos? Yes No, If yes list location:_____
8. Women: Are you or could you be pregnant? Yes No

10. Circle Your Skin type:
I White Always burns, never tan
II White Usually burns, tans with difficulty
III White/Asian Sometimes burns, average tans
IV Moderate Brown Rarely burns, tans with ease
V Dark Brown Very rarely burns, tans very easily
VI Black Never burns

11. Please list any prior cosmetic procedures you've ever had and satisfaction:_____
_____

Please check any treatments that you are interested in learning more about?
___Medical Weight Loss ___Fillers and Botox____Hormone replacement
___Improving Acne ___Reducing wrinkles ___Reducing Brown Spots
___Improving skin textures___Reducing Spider Veins ___Vitamin Injections ___Removing Skin tags/moles/warts___Medical Grade Chemical Peels___5-min non-surgical nose-job

I understand that my insurance does not cover cosmetic procedures and that payment is due in full today.
I consent to the taking of photographs and authorize their anonymous use for the purpose of medical audit, education and promotion.
Signature:_____
Date:_____