Clemson Eye
Aesthetics

Health History

REASON FOR VISIT _____ **ALLERGIES:** _____

Name _____ Date of Birth _____ Age _____

Address _____ State _____ Zip _____

Email _____ Phone _____

How did you hear about us _____

Occupation _____ Employer _____

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MEDICAL ASSESSMENT: Please check if you are currently being treated for or have a history of any of the following medical conditions

Neurological Disorders

____Myasthenia Gravis ____Epilepsy/Seizures ____Multiple Sclerosis ____Stroke

____ALS ____Lambert Eaton Syndrome ____Bell's Palsy ____Dizziness

Blood/Heart Disorder

____HIV/AIDS ____Thrombocytopenia ____Heart Disease ____Heart Attack

____Respiratory Problems ____Poor Circulation ____Bleeding Disorders ____Diabetes

____High Blood Pressure ____Raynaud's Syndrome

Have you had ANY vaccines in the past 4 weeks? _____

Have you had ANY steroid injections in the past 4 weeks? _____

Have you or do you plan to have a dental procedure in the past 2 weeks?_____

Other

____Hepatitis ____Skin Cancer ____Anxiety ____Depression

____Tobacco Use ____Alcohol Use ____Cold Sores ____Hormone Replacement

CURRENT MEDICATIONS (please list herbals/supplements):

_____

_____

In the past 7 days have you had any of the following:

____Aspirin ____Ibuprofen ____Motrin ____Warfarin/Blood Thinners

____Fish Oil ____Ginkgo ____Vitamin E ____Antibiotics

____Retinol or Retin-A ____Hydroquinnone ____Accutane

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INJECTABLES

Have you been injected before? _____ If so, please list which product and where on the face/body.

	Botox/Dysport	Dermal Filler	Sculptra	PRP/PRF
Forehead				
Crow's Feet (around the eyes)				
Cheeks				
Lips				
Jaw/Chin				
Temples				

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For FEMALE patients:

Is there a chance you could be pregnant? _____Yes _____No
Are you breastfeeding? _____Yes _____No
Are you trying to become pregnant? _____Yes _____No
Do you use birth control? _____Yes _____No

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SKIN CARE

Skin Concerns

____Acne ____Rosacea ____Redness ____Broken capillaries/veins
____Brown spots/sun damage ____Uneven skin tone ____Oily skin ____Dull or dry skin

Which describes your skin?

____Always burns easily, never tan ____Always burns, tans slightly ____Burns moderately, tans gradually
____Seldom burns, always tans well ____Rarely burns, deep tan ____Rarely burns, deeply pigmented

Please list current skin care products:

_____

_____

_____

Do you or have you used a tanning bed? _____ Have you tanned in the last 4 weeks? _____
Have you had a chemical peel, microdermabrasion, laser treatment, or neurotoxin in the last 4 weeks?

_____

Do you see a dermatologist routinely? _____

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PHOTO CONSENT:

I agree to allow Clemson Eye Aesthetics to use before and after photos on the website and/or social media.
Please initial one. _____Full Face _____ Individual Area _____NO PERMISSION

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I hereby certify that I have filled out the Health History and it is accurate and true to the best of my knowledge.

Patient Signature _____Date _____

MD/NP/PA Signature _____Date _____