Health History Form

Reason for Visit: _____ **Referred By:**_____

Name:_____ Date of Birth:_____ Age:_____

Address:_____ State:_____ Zipcode:_____

Email:_____ Phone:_____

Occupation:_____ Employer:_____

Emergency Contact Information: Please provide the name and contact information of the person we should contact in case of emergency.

Contact Name: _____ Relationship:_____

Phone Number: _____ □ Cell □Home

□ I authorize Clemson Eye Aesthetics to communicate with this contact if medically necessary.

Medical Assessment: Please indicate any medical conditions you currently have, have previously been treated for, or have a history of, and list any allergies below.

Drug Allergies: _____

Neurological Disorders:

□ Myasthenia Gravis
□ Epilepsy/Seizures
□ Lambert Eaton Syndrome
□ Stroke
□ ALS
□ Bell's Palsy
□ Multiple Sclerosis
□ Dizziness
□ None of the Above

Blood/Heart Disorders:

□ HIV / AIDS
□ Thrombocytopenia
□ Heart Disease
□ Heart Attack
□ Poor Circulation
□ High Blood Pressure
□ Respiratory Problems
□ Bleeding Disorders
□ Raynaud's Syndrome
□ None of the Above

Other:

□ Hepatitis
□ Skin Cancer
□ Anxiety
□ Depression
□ Tobacco Use
□ Alcohol Use
□ Cold Sores
□ Hormone Replacement
□ None of the Above

Current Medications: Please list any medications, vitamins, herbal products, or supplements you are currently taking, whether prescribed or purchased over the counter.

_____

_____

In the past **7 days**, have you taken any of the following?

□ Aspirin
□ Ibuprofen
□ Motrin
□ Warfarin/Blood Thinners
□ Fish Oil
□ Ginkgo
□ Vitamin E
□ Antibiotics
□ Retinol/Retin-A
□ Hydroquinone
□ Accutane
□ None of the Above

Have you received any vaccines in the past 4 weeks? □ Yes □ No

- If yes, please specify: _____

Have you been on an antibiotic or had a steroid injection in the past 4 weeks? □ Yes □ No

- If yes, please specify: _____

Have you had or do you plan to have any dental cleaning or procedures in the past 2 weeks? □ Yes □ No

- If yes, please specify: _____

Clemson Eye Aesthetics | Health History Form

For Female Patients:

Are you trying to become pregnant? □ Yes □ No
Is there any chance you could be pregnant? □ Yes □ No
Are you breastfeeding? □ Yes □ No
Do you use birth control? □ Yes □ No

Injectables:

Have you been injected before?_____.
If so, please specify the product used and the area which it was injected. _____

Skin Care:

Skin Concerns:

□ Acne
□ Rosacea
□ Redness
□ Broken Capillaries / Veins
□ Sun Damage / Brown Spots
□ Uneven Skin Tone
□ Oily Skin
□ Dry Skin / Dullness
□ None of the Above

Which of the following best describe your skin?

□ Always burns easily, never tans
□ Always burns, tans slightly
□ Burns moderately, tans gradually
□ Seldom burns, always tans well
□ Rarely burns, deep tan
□ Rarely burns, deeply pigmented

Do you or have you used a tanning bed? □ Yes □ No
Have you tanned in the last 4 weeks? □ Yes □ No
Have you had a chemical peel, microdermabrasion, or neurotoxin in the last 4 weeks? □ Yes □ No
Do you see a dermatologist routinely? □ Yes □ No

Please list your current skin care products:

_____

_____

Photo Consent: I authorize Clemson Eye Aesthetics to use photographs and/or videos of my treatment results for educational, promotional, and social media purposes.

□ Yes, full face □ Yes, treatment area only □ No, I do not consent

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

I understand that Clemson Eye Aesthetics providers provide services to me related specifically and only to the cosmetic improvement of my appearance. These services may include, but are not limited to, laser, injections, and skincare. Clemson Eye Aesthetics is a medical aesthetic establishment, not dermatology, or primary care. This medical examination does not represent a complete history or physical examination.

Patient Signature:_____ Today's Date:_____

Clinic Use Only

Patient Diagnosis:_____ Suggested Treatment_____

Provider Signature:_____ Date:_____

MD/NP/PA Signature:_____ Date:_____

Cancellation and No Show Policy

At Clemson Eye Aesthetics, we understand that situations arise in which you must cancel or reschedule your appointment. It is therefore requested that if you must cancel or change your appointment, you provide at least a 24 hour notice. This will allow a patient who is waiting for an opening to be scheduled in that appointment slot. Office appointments that are cancelled with **less than 24 hours** notification may be subject to a **$50.00** cancellation fee.

Patients who do not show up for an appointment and have not called, are considered a **NO SHOW** and may be subject to a $50.00 no show fee. The cancellation and no show fees are the sole responsibility of the patient and must be paid in full prior to the patient's next appointment. We understand that special unavoidable circumstances may cause you to cancel within 24 hours. Fees in this instance may be waived with management approval.

Please sign that you have read, understand, and agree to this Cancellation and No Show Policy.

_____ _____

Patient Name (Printed) Date of Birth

_____ _____

Patient Signature Today's Date