Skincare Aesthetics
of Baton Rouge

Health Information as of _____ (enter today's date)
(Please Print Legibly & Fill In or Correct All Fields)

Patient's Name_____

Date of birth_____**Age**____**Weight**____**Height**_____**Gender: Male or Female**

Purpose of Visit:_____

Allergies;_____

Medications: (include all Prescriptive, Over-The-Counter, Vitamins and Herbal medications taken regularly):_____

_____

Previous Surgeries with Dates: (Including cosmetic)

_____

_____

Health Problems Past & Present: (check all that apply)
____Hives/Eczema____Rosacea____Adult Acne____Heart Problems____ High BloodPressure
____BleedingClotting____Anemia____Kidney____Diabetes____Glaucoma___Cataracts
____Peptic Ulcer____Cancer____Tuberculosis____Liver Problems
____Psychiatric/Depression____Easy bruising____Other: _____

_____

Do you smoke? No Yes, How many packs a day?_____

Have you ever had Botox?_____**When was last treatment?** _____

Have you ever had a filler treatment, i.e. Juvederm, Restylane, Radiesse, Sculptra?_____

_____

When was last treatment?_____
Have you ever had any type of laser treatment or chemical peel on your face?_____
When?_____**Were your goals met?**_____

The above information is accurate and complete to the best of my knowledge.

Signature_____**Date**_____