Graystone
Aesthetic Center
RODERICK N. HARGROVE, MD FACS

Patient Medical History

Name _____ DOB _____ Age _____ Date_____
Address_____
Email address (will receive updates, coupons, promotions) _____
Home Phone # _____ Best Contact # _____ Emergency Contact Name/# _____

Medical History

Please circle any of the following conditions that you have or have had in the past:

Use of Accutane
Bleeding Disorders
Herpes (cold sores)
Diabetes
Bruises easily
Hepatitis
Psoriasis or Vitiligo
Skin Cancer
Faints Easily
Auto Immune Disorders
Keloid Scars
Neurological disorders such as Lupus
Use of blood thinners
Seizures
Eye makeup sensitivity
Chronic skin conditions
Blurred Vision
Glaucoma
Dry Eyes
Hair Loss
Thyroid Problems
HIV

Do you have or have you ever had fever blister/cold sores/herpes? ☐ No ☐ Yes **Do you smoke? ☐ Yes ☐ No**

Last date of sun exposure _____ **Do you use tanning beds** ☐ No ☐ Yes

List any current medications/supplements:

_____

List all medications allergies:

_____

Please circle any other allergies – Lanolin, Latex, Metals, Bacitracin ointment, Neomycin/Polymyxin B ointment, PABA

Food Allergies: _____

List any cosmetic procedures that you have had and any complications that have occurred:

_____

Please circle any procedures or treatments that you are interested in:

Botox®/Fillers
Wrinkles around eyes/lips
Hair Removal
Laser Resurfacing
Microdermabrasion
Smartlipo
Chemical Peel
Spider vein therapy
Face Lift
Removal of sun damage, brown spots
Eyelash Enhancement
PrecisionTx
Electrolysis
Eyelid surgery
Brow Lift
Permanent cosmetics(eyeliner)
CoolSculpting™
☐ Other _____

Please list dates of any upcoming special events. Ex: Wedding, Reunion, social party or gathering, etc.

_____
_____

I certify that I have provided accurate medical history to Graystone Aesthetic Center.

_____ _____ _____
Signature of patient/guardian Print Name/Relationship Date

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