Graystone AESTHETIC CENTER
Enhancing Your Natural Beauty

Patient Medical History

Name _____ DOB _____ Age _____ Date_____
Address_____City, State, Zip Code_____
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	Faints Easily	Chronic skin conditions
Bleeding Disorders	Auto Immune Disorders	Blurred Vision
Herpes (cold sores)	Keloid Scars	Glaucoma
Diabetes	Neurological disorders such as Lupus	Dry Eyes
Bruises easily	Use of blood thinners	Hair Loss
Hepatitis	Seizures	Thyroid Problems
Psoriasis or Vitiligo	Eye makeup sensitivity	HIV
Skin Cancer	Hernias	Abdominal Mesh

Are you pregnant? ☐ No ☐ Yes Are you nursing? ☐ No ☐ Yes OR Do you plan to become pregnant or nurse? ☐ No ☐ Yes

Do you smoke? ☐ No ☐ Yes

List any current medications/supplements:

_____

List all medications allergies:

_____

Please list any other 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	Chemical Peel	
Wrinkles around eyes/lips	Spider vein therapy	Eyelid surgery
Hair Removal	Face Lift	Brow Lift
Laser Resurfacing	Removal of sun damage, brown spots	Permanent cosmetics(eyeliner)
Microdermabrasion	Eyelash Enhancement	CoolSculpting™
Smartlipo/Precision TX	Tattoo Removal	☐ Other _____

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

_____

HOW DID YOU HEAR ABOUT US?_____

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

_____ _____ _____

For office use only

Brilliant Dist #

Signature of patient/guardian Print Name/Relationship Date