MEDICAL HISTORY FOR AESTHETICS

All information is strictly confidential.

ROMERO CLINIC
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Last Name: _____ First Name: _____
Age: _____ Reason(s) for visit? _____

AESTHETIC PROCEDURES: Please list all aesthetic procedures you have undergone and when.		
☐ Botox	☐ Radiesse	☐ Medical Body Piercing
☐ Juvederm	☐ Silicone for Lips	☐ Liquid Face Lift
☐ Surgical Face Lift	☐	☐

MEDICAL CONDITIONS: Check if you have any of the following.		☐ **NONE of the following**
☐ AIDS	☐ Excessive Bleeding	☐ HIV Positive
☐ Auto-immune Disorders	☐ Fibromyalgia	☐ Neuromuscular Disease
☐ Cold sores/Fever blisters	☐ Guillain-Barre Syndrome	☐ Are you pregnant?
☐ Depression	☐ Heart Disease	☐ Nursing a baby?
☐ Diabetes	☐ High Blood Pressure	☐ Psychological Condition
☐	☐	☐

MEDICATIONS: List medications you are currently taking.	**ALLERGIES: To medications or substances.**
☐ NONE	☐ NONE
	☐ Allergic to Penicillin
	☐ Adrenaline Sensitivity

SERIOUS ILLNESSES, INJURIES OR HOSPITALIZATIONS			**HEALTH HABITS Check which substances you use and describe how much you use**		
Year	**Hospital**	**Reason for Hospitalization and Outcome**			
			☐	Caffeine	
			☐	Tobacco	
			☐	Street Drugs	
Have you ever had a blood transfusion? ☐ YES ☐ NO If yes, please give approximate dates:			☐	Other	
NOTES:			**OTHER MEDICAL INFORMATION:**		
☐ Generally in good health.					
			Your occupation:		

To the best of my knowledge, the above information are complete and correct. I understand that it is my responsibility to inform my doctor if I ever have a change in health.

I give permission to have my photographs taken to document the progress of my treatment. These photographs may not be used for advertising or other promotions without my express authorization.

_____ */ /2015*
SIGNATURE Date

_____ _____
PRINT

_____ */ /2015*
WILLIAM H. E. ROMERO, MD Date