

EXCLUSIVE WELLNESS & AESTHETICS MEDICAL HISTORY
NovaThreads & ScleroTherapy

Name _____ DOB _____ Ht _____ Wt _____ Date _____

Address _____

City _____ State _____ Zip _____

Phone _____ Email _____

Primary Physician's Name and Number _____

Please list all medications you are currently taking: _____

List Vitamin Supplements you are taking: _____

List any Allergies: _____

*Collagen Tested _____ Date _____ Were there complications? _____

Circle any of the following you have or have ever had in the past:

Multiple Severe Allergies/Hypersensitivity to medications Sensitivity/Allergy to Lidocaine
Autoimmune Disease History of Cold Sores Allergy to Beef /Dairy/Cow's Milk Products Lupus
Keloid Formation

List any OTHER MEDICAL CONDITIONS not listed above that you currently have or have had in past: _____

Please list any previous hospitalizations/surgeries: _____

WOMEN: Are you Pregnant, Trying to get Pregnant, or Lactating (Nursing)? _____

Have you had Plastic Surgery or other surgery to your face/neck areas & when? _____

Have you had any Facial Threads/Sclerotherapy procedures before? _____ If yes, when & were you satisfied with the results? _____

I understand the information on this form is essential to determine my medical and cosmetic needs and the provision of treatment. I understand that if any changes occur in my medical history/health I will report it to the office as soon as possible. I have read and understand the above medical history questionnaire. I acknowledge that all answers have been recorded truthfully and will not hold any staff member responsible for any errors or omissions that I have made in the completion of this form.

Patient Signature _____ Date _____

Practitioner Signature _____ Date _____