Oxford Medical Aesthetics
Dr. Michelle Naegele

Date________

Patient Contact Information

Title: ☐Mr. ☐Ms. ☐Miss ☐Mrs. Name: ____________________

Nickname: ____________________ Date of Birth: ____________________

Address: ____
Street Address Apt./Ste # City State Zip Code

Phone: ____________________ Email: ____________________

Medical History

[1] Are you currently under the care of a specialist (e.g. cardiologist, neurologist, etc.)? ☐Yes ☐No

[a] If yes, please explain: ____________________

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[2] Do you have any of the following conditions?

☐ Myasthenia Gravis	☐ Lambert-Eaton Syndrome	☐ ALS (Amyotrophic Lateral Sclerosis)
☐ History of Blood Clots	☐ History of Bleeding Disorder	☐ Heart Disease
☐ Lupus	☐ Fibromyalgia	☐ Diabetes
☐ Hepatitis	☐ HIV/AIDS	☐ Cancer
☐ Seizures	☐ Scleroderma	☐ Keloids
☐ Cold Sores/Herpes	☐ Shingles	☐ Pregnant
☐ Lactating	☐ Respiratory Problems	☐ Asthma
☐ Permanent Make-Up		

Current Medications

(Please include Aspirin, NSAIDs [non-steroidal anti-inflammatory drugs], immunosuppressive medications, herbal supplements, Tamoxifen, and over-the-counter medications)

[3] Have you ever had an allergic reaction? ☐ Yes ☐ No

[a] If yes, to what?

[4] Have you ever had a reaction to a local anesthetic? ☐ Yes ☐No

[a] If yes, which one?

[5] Have you ever had an adverse reaction to a neurotoxin or filler?

☐Yes ☐ No ☐ N/A If yes, which one?

[6] Have you ever had any facial surgeries? ☐ Yes ☐ No

[a] If yes, please explain:

Liftstyle Information

[7] Do you use smoke cigarettes? ☐ Yes ☐No

[8] Are you pregnant, trying to become pregnant, and/or breastfeeding?

☐ Yes; please specify: ______________________________ ☐ No

[9] Please indicate your area(s) of concern and location:

Acne: ______________________________
Pigmentation: ______________________________
Lines/Wrinkles: ______________________________
Bumps/Papules: ______________________________
Redness: ______________________________
Rosacea: ______________________________
Pores: ______________________________
Skin Laxity: ______________________________
Scars: ______________________________
Veins/Capillaries: ______________________________
Hair: ______________________________

[10] Please describe any previous treatment you have had for these concerns:

[11] Did you have any problems with these treatments? ☐ Yes ☐ No

[12] Have you used tanning beds or self-tanning products in the past two weeks?

☐Yes ☐No

[13] Do you use sunscreen regularly? ☐ Yes ☐ No

[14] Are you currently using/taking:

☐ Retinoids ☐ Accutane ☐ Vitamin E ☐ Aspirin ☐ Coumadin

[15] What skin care products are you currently using?

[16] For laser purposes, please indicate your heritage.

☐ Caucasian ☐ African American ☐ Hispanic
☐ Asian ☐ American Indian ☐ Indian
☐ Mediterranean ☐ Other, please specify: ______________________________

I certify that the above information is true and accurate. I am aware that it is my responsibility to inform Dr. Naegele of my medical information (both history and current). Should any medical information change in the future, I understand that it is important to update Dr. Naegele, to ensure appropriate treatment procedures.

____
Signature Date

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Doctor Signature Date