

**Aesthetic Solutions**  
5821 Farrington Rd. Ste 101 Chapel Hill, NC 27517  
(919) 403-6200 [www.aesthetic-solutions.com](http://www.aesthetic-solutions.com)

**PLEASE BRING THIS FORM TO YOUR APPOINTMENT**

**Patient Name:** \_\_\_\_\_ **Chart #:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**This is part of your CONFIDENTIAL Medical Record.**

**Reason for Consultation:**

\_\_\_\_\_

**Drug Allergies:**

\_\_\_\_\_

**Medications/ Dosages Taken Regularly:**

\_\_\_\_\_

\_\_\_\_\_

**Are you taking Aspirin or any medications containing Aspirin?** \_\_\_\_\_

**Vitamins/ Herbs?** \_\_\_\_\_

**Have you had any reaction to injections of a local anesthetic?** \_\_\_\_\_

**Are you allergic to Band-aids, tape, or adhesive?** \_\_\_\_\_

**Female patients only:**

Are you taking oral contraceptives? \_\_\_\_\_ Are you pregnant or trying to become pregnant? \_\_\_\_\_

Date of last physical: \_\_\_\_\_ Physician: \_\_\_\_\_

Previous Surgeries, dates and attending Physicians:

\_\_\_\_\_

**GENERAL HEALTH**

	YES	NO	
Cancer _____	<input type="checkbox"/>	<input type="checkbox"/>	Have you had an Electrocardiogram (EKG) in the past year? _____ Normal? _____
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	
Eye Problems	<input type="checkbox"/>	<input type="checkbox"/>	Have you been under a physician's care in the past or currently for any medical condition? If so, what condition and who is/was the physician?
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	_____
Ulcers	<input type="checkbox"/>	<input type="checkbox"/>	_____
Lung Problems	<input type="checkbox"/>	<input type="checkbox"/>	_____
Psychiatric Disorders	<input type="checkbox"/>	<input type="checkbox"/>	_____
Neurological Disorders	<input type="checkbox"/>	<input type="checkbox"/>	_____
Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>	_____
Do you get nauseated easily?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Do you smoke?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Do you have Hepatitis?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Do you have HIV or HIV risk factors?	<input type="checkbox"/>	<input type="checkbox"/>	_____

\*Please note that we will ask you to update your general health history each year

**We offer a full range of cosmetic procedures.** Please indicate whether you are interested in learning more: **BOTOX** **RESTYLANE** **LASER** for wrinkles **LASER HAIR REMOVAL** **CHEMICAL PEELS** **LIPOSUCTION** **FACIAL PLASTIC SURGERY** **LEG VEIN TREATMENT** **LASER** for blood vessels or tattoos **Other:** \_\_\_\_\_

Form Completed By: \_\_\_\_\_ Date: \_\_\_\_\_

**PtHealth07**