Oceanside
Aesthetics & Wellness

MEDICAL HISTORY

Name:_____
Date of Birth:_____
Gender: M F. Other _____
Address:_____
City:_____ State: _____ Zip:_____

Home phone:_____
Cell phone:_____
Work Phone:_____

Preferred Email: _____

Past Medical History:_____
Past Surgical History: _____
Medications: _____
Allergies:_____

Your goals of care:

- ☐ Botulinatum toxin injection, i.e. Botox/Dysport
- ☐ Fillers such as Juvederm, Restylane
- ☐ Facials
- ☐ Peels
- ☐ Nutrition consultation
- ☐ Wellness coach
- ☐ Vitamin injection

☐ EmSculpt

☐ Exilis Ultra

Have you experienced:

☐	Frequent illness	☐	Chronic fatigue
☐	Chronic headaches	☐	Unexplained weight loss
☐	Difficulty healing	☐	Excessive scarring
☐	Easy Bruising/bleeding	☐	Comprosmied Immune System

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