REVERZA Aesthetic Medicine
160 Oakway Road, #100, Eugene, OR • 541-600-4569

MEDICAL HISTORY

Name_____ Age_____ Date of Birth_____ Ht_____Wt_____
Phone Number_____ Email_____
Address_____ City/State_____ Zip_____
Referred by:_____ Occupation: _____

ALLERGIES (medications, food, topicals, anesthesia): _____

MEDICATIONS (oral, topical) & over the counter:

_____

_____

Skincare products/regimen:_____
Are you taking blood thinners including aspirin/warfarin? _____ Food supplements: _____

For Women: Are you Pregnant? _____ Last Menstrual Period_____
Primary care provider's (PCP) Name_____

Circle any of the following illnesses you have or have ever had in the past:
Diabetes Cancer Hypertension Stroke Asthma
Myasthenia Gravis Hepatitis Eye Disease Autoimmune Disease Vision Problems Numbness Muscle Weakness Amyotrophic Lateral Sclerosis (ALS) HIV/AIDS
Others_____
Elaborate here if needed:_____

Previous Hospitalizations/Operations (including year): _____
Previous Cosmetic Procedures/Surgeries (such as Botox, Fillers) including year
_____

Planned Cosmetic or Medical Procedures for the next 6 months _____
Important (Upcoming) Occasions/Events (such as wedding, anniversary) *This is important since some procedures have downtime. It also helps plan our course of treatment.* _____

Aesthetic Goals/Desired procedure(s): _____

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 health I will report it to the office as soon as possible. I have read and understand the above medical 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_____