REVERZA Aesthetic Medicine

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_______________________Preferred Pharmacy _________________
Emergency Contact Name_______________________ Phone number_________________________

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____

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__________________