MEDICAL Aesthetics & Wellness OF CT

PATIENT INFORMATION

Name: _____ Date: _____

Cell phone: _____ Text reminders OK? _____

Date of Birth: _____

Email: _____

Allergies: _____

Pregnant or breast-feeding? _____

Are you taking Aspirin, Ibuprofen (Motrin® or Advil®), or fish oil? _____

If yes, these medications can increase the risk of bleeding and bruising

Other Medications: _____

_____

Surgeries or hospitalizations: _____

Check the areas you are concerned with:

- ☐ Wrinkles/creases
- ☐ Asymmetry
- ☐ Volume loss
- ☐ Skin dullness/pigmentation/scarring
- ☐ Sparse or short eyelashes
- ☐ Weight Management
- ☐ Smoking Cessation

How did you hear about us?

- ☐ Sign
- ☐ Facebook
- ☐ Website
- ☐ Friend _____
- ☐ Publication _____
- ☐ Hair Salon or Spa _____
- ☐ Other _____