Beyond Biologics

322 Posada Ln., Ste. A Templeton, CA 93465

CLIENT INFORMATION & MEDICAL HISTORY

In order to provide you with the most appropriate treatment, we need you to complete the following questionnaire. All information is strictly confidential.

PERSONAL INFORMATION

Client Name _____ Today's Date_____
Date of Birth _____ Age_____
Occupation_____
Home Address_____State____ Zip Code_____
Home Phone / Mobile (___) _____Work Phone (___) _____
Email: _____
Emergency Contact Name and Phone / Relationship
_____
How were you referred to us?
_____
May we email you with information, education or promotions? Yes No

Do you consent to have before and after photo(s) taken or video of your procedure?
Yes No

Do you give your consent for Beyond Biologics to use this material (photos/video) for marketing purposes? Example: using your before and after photo(s) or video of your procedure on our website or social media (Facebook/Instagram)?
Yes No

Which of the following best describes your skin type? (Please circle one)

Always burns, never tans
Always burns, sometimes tans
Sometimes burns, always tans
Rarely burns, always tans
Brown, moderately pigmented skin
Black skin

MEDICAL HISTORY
Are you currently under the care of a physician? Yes No
If yes, for what:
_____

Are you currently under the care of a dermatologist? Yes No
If yes, for what:

_____

Do you have any of the following medical conditions? (Please circle all that apply)

Cancer/Diabetes/High blood pressure/Herpes/Arthritis/Cold sores/Keloid scarring
Skin disease/Skin lesions/Seizure disorder/Hepatitis/Hormone imbalance/Thyroid imbalance
Blood clotting abnormalities/Any active infection

Do you have any other health problems or medical conditions? Please list:

_____

Do you have any drug allergies? Yes No

If yes, which drug and what was your reaction?
Drug _____ Reaction _____

Have you ever had an allergic reaction specifically to the following? Yes No
If so, please circle
Lidocaine Benzocaine Tetracaine

CURRENT MEDICATIONS

_____
_____
_____
_____

Do you take any blood thinners? Yes No

HISTORY

Have you ever had laser hair removal? Yes No

What line of skin care products are you currently using?

_____
_____

Do you regularly use sunscreen? Yes No

If yes, what SPF? _____

Have you received BOTOX**,** Dysport, or any form of injectable dermal filler such as (Hyaluronic acid, Juvéderm products: Juvéderm XC, VOLUMA, VOLBELLA, VOLLURE, estylane products: Restylane, Restylane Silk, Restylane Lyft, Restylane Refyne, and Restylane Defyne, Belotero Balance) in the past six weeks? Yes No

Do you get regular skin care treatments? Yes No

If, yes which treatments? _____

Are you interested in a consultation with an aesthetician? Yes No

Have you had any form of chemical peel in the past six weeks? Yes No

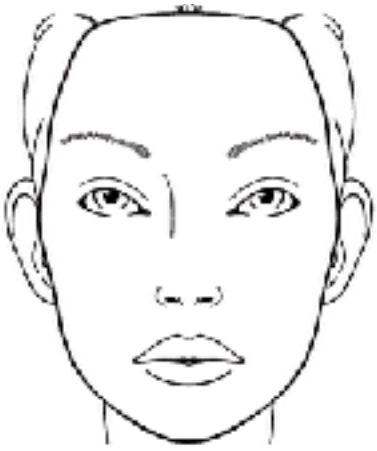
Do you form thickened or raised scars from cuts or burns? Yes No

Are you currently using Retin-A or a retinol product? Yes No

Do you have hyperpigmentation (darkening of the skin) or marks after physical trauma or wounds?

Yes No

Please mark any areas of concern on the following diagram:



I certify that the preceding medical, personal and skin history statements are true and correct. I am aware that it is my responsibility to inform the doctor, physician assistant, nurse or medical staff of my current medical health conditions and regularly update this history. A current medical history is essential for the medical provider to execute appropriate treatment procedures.

Signature_____ Date _____