Primary Care West, P.C.

1255 Wallace Rd. N.W.
Salem, OR 97304

(503) 362-1314

HEALTH HISTORY

NAME: DOB:

TREATMENT CHECK-IN:

Are you currently under the care of a Health care Provider?
What was your most recent cosmetic treatment? If this is your first cosmetic treatment, please state so.
Person/Company who provided the treatment? Date of last treatment:
Have you ever fainted during or immediately following an aesthetic procedure?
Have you ever had a cosmetic procedure you did not like the outcome of?

Have you ever had a Rhinoplasty?
If yes, how many? _____
If so, did you experience any pain?

Are you allergic to Eggs?
Are you allergic to Milk Protein?
Are you allergic to Lidocaine?

Do you have any other allergies or can you think of something you've had an adverse reaction to? Please list:

CURRENT MEDICATIONS:

List any medications that you are now taking below. Please include any and all non-prescription (over the counter) medications, vitamins, and supplements.

Name.
1.
2.
3.
4.

Dose.
1.
2.
3.
4.

Length.
1.
2.
3.
4.

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HEALTH HISTORY

REPRODUCTIVE HISTORY:

Are you currently pregnant?

Have you been pregnant within the last year?

Are you currently breastfeeding?

SKIN HISTORY

			If yes, please explain (Provide frequency & most recent occurrences.
Keloid Scars	Yes	No	
Hives	Yes	No	
Skin Cancer	Yes	No	
Waxing	Yes	No	
Electrolysis	Yes	No	
Cold Sores	Yes	No	
Hypersensitivity to Skin Products	Yes	No	
Skin Infections	Yes	No	
Tanning Within Last 6 weeks	Yes	No	
Use of Acne Products or Drugs	Yes	No	
Laser Skin Resurfacing	Yes	No	
Chemical Peels	Yes	No	
Photo-Sensitizing substances	Yes	No	

Antibiotics, Diuretics, and Blood Pressure Medicine are all examples of photo-sensitizing substances.

Additional Information you would like to share related to your health if any:

AGREED AND SIGNED:

I attest the above information to be true, knowing my practitioner(s) rely on this information to provide the most safe and effective treatment.

Print Name: _____

Signature: _____ Date: