Jeffrey Patrick Olson MD & JPO Aesthetics
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 HISTORY

Client Name_____ Today's Date

Date of Birth_____Age_____Occupation

Home Address_____ City_____ State___Zip Code

Home Phone (__)_____Work Phone (____)

Email:_____(for future product news and discounts)
Look for the JPO Aesthetics and recommend our services!

Emergency Contact Name and Phone

How were you referred to us?

Do you regularly sun bathe or use tanning salons?_____How often?

MEDICAL HISTORY

Are you currently under the care of a primary care physician or specialist? ❑Yes ❑ No
If yes, for what:
Date last visit:

Do you have any of the following medical conditions? (Please check all that apply)
❑Cancer ❑Diabetes ❑High blood pressure ❑Arthritis ❑Herpes ❑Any active infection
❑Frequent cold sores ❑HIV/AIDS ❑Skin disease/Skin lesions ❑Keloid scarring
❑Seizure disorder ❑Hepatitis ❑Kidney disease ❑Thyroid imbalance ❑Hormone imbalance
❑Blood clotting abnormalities ❑Autoimmune/immunosuppressive disorder

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

Have you ever had an allergic reaction? (List any and all that you have had and describe the reaction you experienced) ❑Food ❑Animal Protein ❑Aspirin ❑Lidocaine ❑Hydrocortisone ❑Hydroquinone or skin bleaching agents ❑Others:

MEDICATIONS
What oral prescription medications are you presently taking? ❑Birth control pills ❑Hormones

❑Others (It is required that you list all of them):

What antibiotics do you use to treat infections?
Last prescribed:
Do you take any medications for heart conditions?

Are you on any mood altering or anti-depression medication?
What topical medications or creams are you currently using? ❑ RetinA , ❑Others (Please list):

Do you take any herbal medications or NSAIDS (anti-inflammatories on a regular basis)?
Last dose:

What cosmetic procedures/skin treatments/injectables have you had? interested in? Area desired to treat?

HISTORY

For our female clients:

Are you pregnant or trying to become pregnant? ❑Yes ❑No Are you breastfeeding? ❑Yes ❑No
Are you using contraception? ❑Yes ❑No

I certify that the preceding medical, medication and personal history statements are true and correct. I am aware that it is my responsibility to inform the doctor or other health professional of my current medical or health conditions and to update this history. A current medical history is essential for the caregiver to execute appropriate treatment procedures.

Signature_____ Date: