BEAUTY by Dr. Joe

DRJ

Medical History Form

Name:_____ Today's Date:_____
Date of Birth:_____
Phone Number:_____ Email:_____

Do you have any of the following medical conditions:
Herpes/Cold Sores **Yes___ No___**
HIV/AIDS **Yes___ No___**
Bleeding Disorder **Yes___ No___**
Autoimmune Disorder **Yes___ No___**
Neurological Disease **Yes___ No___**
Heart Disease **Yes___ No___**
Cancer **Yes___ No___**
Migraines/Headaches **Yes___ No___**
Mental Health Condition **Yes___ No___**
Psoriasis/eczema **Yes___ No___**
Other:_____

Do you take any medications:
_____

Do you take Blood Thinners? **Yes___ No___**
Do you take oral corticosteroids or immunosuppressants? **Yes___ No___**
Are you currently taking any antibiotics? **Yes___ No___**

Do you have any Allergies?
_____

Are you allergic to Cow's Milk Protein? **Yes___ No___**

Do you smoke? **Yes___ No___**
Do you drink alcohol? **Yes___ No___**
Are you pregnant or breastfeeding? **Yes___ No___**

Have you ever had Botox/Dysport or Dermal Filler treatment? **Yes___ No___**
Any Complications? **Yes___ No___**
Explain:_____

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