SOUTH BAY MEDICAL WEIGHT LOSS CLINIC, INC

DRS. ASIF AZIMI, MD AND CLAUDIA KWON, MD

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Medical History for Aesthetic Procedures

Name: ____________________ Date of Birth: ____________ Age: ________
Address: ____
City: ____________________ State: ________ Zip: ________ Email: ____________________
Cell Phone: ______________ Home Phone: ______________ Work Phone: ______________
Primary Care Physician's Name: ______________________ Office Phone: ______________

Please list ALL medications that you are currently taking: ____________________
List vitamin supplements you are on: ____________________
List any allergies with reactions: ____________________

With an "X", mark any of the following illnesses you have or have ever had in the past: If None Check Box ☐

___ Severe Allergies/Hypersensitivity to Medications. If yes, list: ____________________
___ Skin Disease
___ Autoimmune Disease
___ Cancer
___ Allergy to Beef
___ Acne
___ Depression
___ High Blood Pressure
___ Diabetes
___ Vision Problems
___ Multiple Sclerosis
___ Lambert-Eaton Syndrome
___ Parkinson's Disease
___ History of Cold Sores/Herpes Labialis
___ Myasthenia Gravis
___ Muscle Weakness
___ Amyotrophic Lateral Sclerosis (ALS)
___ Sensitivity/Allergy to Lidocaine
___ Hepatitis
___ Other: ____________________

List any **OTHER MEDICAL CONDITIONS** not listed above that you currently have or have had in the past:
____
Previous Hospitalizations/Operations & When? ____________________
Have you had Plastic Surgery or Other Surgery to Your Face/Neck & When? ____________________
Have you had Dermal Filler in the past? If Yes, When? ____________________
Have you had Botox, Dysport, or Xeomin in the past? If Yes, When? ____________________

Women Only: Are you Pregnant, Trying to get pregnant, or Lactating (Nursing)? Yes_____ No_____
Do you have regular periods? Yes_____ No_____
Are you going through menopause? Yes_____ No_____
During pregnancy, did you ever get hyper-pigmentation or masking? Yes_____ No_____

Do you smoke? Yes_____ No_____ If Yes, How Often? ______________ Do you live with a smoker? Yes_____ No_____
Do you drink alcoholic beverages? Yes_____ No_____ If Yes, How Often? ______________
Do you exercise? Yes_____ No_____ If Yes, How Often? ______________
Do you wear contact lenses? Yes_____ No_____

What skin care line are you currently using? ____________________
Cleanser ______________ Toner ______________ Sunscreen ______________
Day Treatment ______________ Moisturizer ______________ Eye Cream ______________
Night Repair Cream ______________ Mask ______________ Other ______________

Are you using or have you used the following?
______ Alpha/Beta Hydroxy Acids _____ Retinol _____ Hydroquinone
______ Retin-A _____ Accutane _____ Other: ______________

Choose from 1 thru 10, How You Feel About the Overall Quality of Your Skin:
1 (bad) ....10 (fantastic) ______________
Your Skin Type Is? (Please check ONLY one)
_____Normal _____ Dry/Dehydrated _____Oily _____ Mixed _____ Acne/Acne Prone

In order of importance, beginning with 1, make a wish list of what you would like to see improved in your skin in the next 30 days.....

___ Reduction in Fine Lines/Wrinkles
___ Reduction of Oil/Acne
___ Reduction of Spider Veins
___ More Youthful Skin Appearance
___ Reduction of Brown Spots/Sun Damage
___ Acne Scars (Diminished)
___ Improved Appearance of Cellulite
___ Other: ____________________
___ Refill Volume Loss
___ Hair Reduction
___ Fuller Lips

Please mark with an "X" all treatments/services that interest you:

____ Botox
____ Dysport
____ Xeomin
____ Belotero
____ Perlane
____ Restylane
____ Juvederm
____ Radiesse
____ Other: ____________________

*Whom may we thank for referring you to us? ____________________
*How did you hear about us? ____________________
*I certify that I have answered the questions to the best of my ability and will notify South Bay Medical Clinic, Inc. immediately of any pertinent changes in my medical conditions.

Patient's Signature: ____________________ Date/Time: ______________