Pure By Oasis
Medical Aesthetics

## Health History

To ensure both the effectiveness and the safety of your treatment, please complete this health history as accurately as you can.

## Personal Information

Last Name__________________________________________First___________________________________

Street Address_______________________________City_______________Prov._____Postal Code________

Primary Phone ____________________________Secondary Phone________________________________

Email ______________________________________

We confirm appointments. Do you want us to ☐ Telephone ☐ Send an Email

Date of Birth (Month/Day/Year) ____________________________ Gender___________

Where did you hear about us?

☐Website_____________ ☐Internet Search_______________ ☐Instagram/Facebook____________________

☐Friend/Family (Name)_______________________________ ☐Other_______________________________

## Medical History

**Please Mark All That Apply:**

| | |
|---|---|
| ☐ Allergy to Lidocaine | ☐ Problems with scarring |
| ☐ Recent Dental work | ☐ Problems with healing |
| ☐ Allergy to Bee stings | ☐ Immunosuppression |
| ☐ Artificial heart valve | ☐ Mole that is changing |
| ☐ Require premedication prior to procedures | ☐ Experiencing a rash |
| ☐ Allergy to stanhexadine | ☐ Anxiety |
| ☐ Allergy to topical antibiotic ointments | ☐ Fever or Chills |
| ☐ Taking a blood thinner | ☐ Headaches |
| ☐ Problems with bleeding | ☐ Night sweats |
| ☐ Pregnant or planning on becoming pregnant | ☐ Shortness of breath |
| ☐ | ☐ Smoker |

**Please mark the conditions or diseases that you have, or have had in the past**

| | | |
|---|---|---|
| ☐ Arthritis | ☐ Seizures | ☐ History of cold Sores |
| ☐ COPD/Emphysema | ☐ Hypertension(High Blood Pressure | ☐ Psoriasis |
| ☐ Hypercholesterolemia | ☐ Lupus | ☐ Acne |
| ☐ Lung Cancer | ☐ A-Fib (Irregular Heartbeat) | ☐ Skin Cancer |
| ☐ Prostate Cancer | ☐ Breast Cancer | ☐ Myasthenia Gravis |
| ☐ Asthma | ☐ Diabetes | ☐ Multiple Sclerosis |
| ☐ Leukemia | ☐ Stroke | ☐ Neuromuscular Disorder |
| ☐ Coronary Artery Disease | ☐ Hepatitis | ☐ Autoimmune Disease |
| ☐ Lymphoma | ☐ HIV | ☐ Rheumatoid Arthritis |
| ☐ Colon Cancer | ☐ GERD/Acid Reflux | ☐ Thyroid Disease (hyper or hypo) |

Please list all medications you are currently taking: (including prescriptions, over-the-counter meds, vitamin, and herbals)

_______________________________________________

_______________________________________________

_______________________________________________

_______________________________________________

Are you allergic to any medications? ☐ Yes ☐ No If yes, please list below:

| Name of Medication | Type of Reaction |
|---|---|
| | |
| | |
| | |

Please list any surgical procedures you have had in the past: ☐ None

_______________________________________________

Are you currently being treated for any conditions not listed? If yes, please specify:

_______________________________________________

Have you ever had any cosmetic procedures before? When?

☐Botox __________________ ☐Fillers ________________________ ☐Lasers______________________________

☐Plastic Surgery___________________________________________ ☐Other______________________________

Do you have any tattoos or permanent make-up? If yes, please specify:

_______________________________________________

Notes:

_______________________________________________

Medical Director/ Signature Date

_______________________________________________

Patient Signature Date