



Date //

Name First _____ Last _____

DOB _____ Age _____

Occupation _____

Address _____ City _____

State ____ Zip _____

Phone (H) _____ (C) _____ (please indicate preferred)

Email _____ (May we add you to our mailing list?) Yes No

You will receive Monthly Specials, Discounts and Educational Content

Primary Care Doctor _____ Phone _____

Women- Are you pregnant or breastfeeding? Yes No When was your

LMP (last menstrual cycle)? _____ Are you trying to

become pregnant? _____

Are you currently doing IVF? _____

Referred by _____

Instagram Magazine Ad Internet Search Friend

Emergency Contact _____ Phone _____

Relationship _____

Current Height and Weight

Height _____

Weight _____ (is your weight stable ?) Yes No

Medical History

Please Circle Y for Yes N for No

Any changes to your health in the last year? Y N If yes please explain

Do you have a history of diabetes or high blood pressure? Y N Have you ever had a history of a heart attack, chest pain , heart murmur and/or

damaged heart valves ? Y N

Do you have a pacemaker or defibrillator? Y N

Any history of asthma or difficulty breathing? Y N

Do you have a history of heartburn , hiatal hernia, or ulcers? Y N

Any history of liver disease including hepatitis ? Y N

Do you have a history of kidney disease? Y N

Have you ever had a stroke, seizure, or fainting spells? Y N

Do you have an arm or leg that becomes numb or weak frequently? Y N

Do you have any thyroid problems? If yes, is it Hashimotos? Y N

Do you have any Auto-immune Disorders or are you being worked up for including but not limited to Lupus, Rheumatoid Arthritis, Collagen Vascular disease, etc. Y N

Any history of cancer? Please explain Y N

Do you have any excessive bleeding or bruising tendencies? Y N

Are you currently on a blood thinner including aspirin?

If yes when was the last time you took it Y N

Any history of anemia or blood clots? Y N

Any history of cold sores or herpetic lesions? (fever blisters) Y N

Do you have a history of keloid scarring or poor wound healing? Y N

Any history of anxiety/depression? Are you under the care of a psychiatrist? Y N

Do you have a history of Bells or facial nerve palsy? Y N

Do you have a history of Myasthenia Gravis or any other neurological disorder? Y N

Any Metal implants? Y N

Any chipped/loose teeth, dentures, bridges, caps, or braces? Y N

Surgical History including Plastic Surgery History (Please include dates)

Please include Appendectomy, tonsillectomy, cataract, C-section, hernia, Gallbladder, Hysterectomy, etc.)

Facial Surgery Yes No Date_____

History of facial skin cancer Yes No

If Yes what was the treatment _____

Current Medications (please include any NSAIDS, antiplatelet medication, blood thinners ,antibiotics, steroids)

Any recent steroid use or in the past 6 months? Yes No

Have you ever used Accutane? Yes No

If yes, when did you last use it? _____

What topical medications or creams are you currently using? Retin-A
Others (Please list)

What herbal supplements/vitamins do you use regularly? (St. John's Wort,
Vitamin E, fish oil etc.)?

Allergies (including drug, food)

Have you ever had a reaction to lidocaine? Yes No **Do**

you have an allergy to Bees/Bee stings? Yes No

Social history

Do you smoke? YES ____ NO ____ If yes how much?

Do you drink alcohol? YES ____ NO ____ If yes, how much?

When was your last drink? _____

Do you use self-tanners (creams, spray-on tanners) or visit a tanning booth?
YES ____ NO ____

If yes, how often? _____

Last time you were at a tanning booth/applied self-tanner

When was the last time you saw the dentist? (cleaning, work etc.)
Covid Vaccine (NO JUDGMENT HERE!)

If you have been vaccinated, when was your last vaccine?

If you haven't leave blank

What are your reasons for visiting the medical spa
Place a check mark next to each one that interests you

Botox/Fillers

Sculptra Face Contouring
Better Tone/Texture/Elasticity
Collagen Stimulation/anti-aging
Hair restoration
Sun Damage/Sun Spots
Acne/Acne scar concerns
Fine Lines/Wrinkles
Deep wrinkles
Hyperpigmentation (Brown spots)
Weight Loss/Nutrition
Supplement Protocols by Dr Khiani

Other:

Which of the following best describes your skin type? (Please circle one type number)

- I Always burns, never tans
- II Always burns, sometimes tans
- III Sometimes burns, always tans
- IV Rarely burns, always tans
- V Brown, moderately pigmented skin
- VI Black skin

Aesthetic History

Face Injectable history Please include all injectable procedures including botox, fillers, biostimulators, fat grafting, silicone, implants etc. . Make sure to include approximate dates

*By not disclosing your accurate aesthetic history you are responsible for the consequences that may result from any procedure performed by Dr Komal Khiani MD

Did you ever have laser or radiofrequency treatments? If so, which ones? Please Include approximate dates

Any history of filler dissolved? Yes No if Yes Please explain

Additional Information Please let us know anything else you would like to discuss with us during your visit today.

Our Commitment to You

To ensure your treatments are best suited to you, we ask that the information you provide us be as accurate and complete as possible.

I certify that the preceding medical, personal and skin history statements are true and correct. I am aware that it is my responsibility to inform the technician, esthetician, therapist, doctor or nurse 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.

Print Name _____

Signature _____

Date _____