

Date _____/_____/_____

Name _____ Medical Record # _____

Age _____

Height _____ft _____in

Current Weight _____lbs. Heaviest _____lbs. Lightest _____lbs. Preferred _____lbs.

Ideal _____lbs

Past Medical History:

Skin

Have you ever seen a dermatologist for your skin? Yes / No

What topical medications do you use now or have ever used? (e.g., *Retin-A*®) What, When, How, Why and How Long?

Is your skin ever shiny a few hours after cleansing? Yes / No

Does your skin ever flake or feel dry? Yes / No

Describe your pigmentation: Even Uneven Birthmark Pregnancy mask

Do you sun bathe? Yes / No Do you use a tanning salon? Yes / No

When exposed to the sun, do you?

Always burn Usually burn Burn then tan Usually tan Always tan

Do you have broken capillaries? Where? _____

Do you have? Deep wrinkles Crow's feet Fine Lines

Do you use wax or depilatories on your face? Yes / No

Do you have permanent make-up? Yes / No

Have you ever had any kind of hair removal? Yes / No

Do you form keloids or severe scars Yes / No

Where _____

General Medical

Please list **ALL** medical problems:

Please list **ALL** medications. (List Medication, Dose, & Frequency):

Do you take or have you ever taken in the last month any vitamins, homeopathic medicines, herbs or herbal medicines, botanicals, etc., including echinacea, ephedra (mahuang), garlic, ginko, ginseng, kava, St. John's Wort, or valerian? (*All herbal medicines must be stopped at least 2 weeks before the date of surgery.*) No If yes, please list.

Have you ever taken cortisone or steroids? Yes / No What, When, How, Why and How Long?

Have you ever taken any type of hormones, including birth control? What, When, Why and How Long?

Please **ALL** list previous surgeries (please include date and surgeon)

Have you ever taken any type of radiation therapy? Yes / No
 What _____ When _____
 Why _____

Habits

Tobacco use	Yes / No	Type _____	Amount & Duration _____	Quit when? _____
Alcohol use	Yes / No	Type _____	Amount & Duration _____	_____
Drug use	Yes / No	Type _____	Amount & Duration _____	_____

Allergies	Drug/Food/Allergen	Type of Reaction
_____	_____	_____
_____	_____	_____
_____	_____	_____

Have you ever had:

- | | |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <ul style="list-style-type: none"> <input type="checkbox"/> Injuries Of Your Face Or Neck <input type="checkbox"/> Infections Of Your Face Or Neck <input type="checkbox"/> Skin Cancers Of Your Face Or Neck <input type="checkbox"/> Surgery Of Your Face Or Neck <input type="checkbox"/> Significant Acne <input type="checkbox"/> Facial Nerve Disease <input type="checkbox"/> Facial Paralysis <input type="checkbox"/> Cold Sores, Shingles or Herpes <input type="checkbox"/> Chemical Peels | <ul style="list-style-type: none"> <input type="checkbox"/> Laser Resurfacing <input type="checkbox"/> Dermabrasion <input type="checkbox"/> Dry Eyes <input type="checkbox"/> Visual Impairment <input type="checkbox"/> Significant sun damage to your skin <input type="checkbox"/> Keloids Or Severe Scars <input type="checkbox"/> Have you ever taken Acutane®? <input type="checkbox"/> When? _____ |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|

Concerns:

What are your concerns today?

Specifically, what do you wish to accomplish at his visit?

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We appreciate your visit and we respect your privacy. Who may we thank for referring you? _____

May we contact this person to thank them? Yes / No

At what number(s) may we

- Call you?
- Leave a message with a person and tell them we called?
- Leave a message on an answering machine?
