

# Scars & Keloids Patient Worksheet

Cosmetic Services, Kaiser – Santa Rosa

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Date \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

Name \_\_\_\_\_ Medical Record # \_\_\_\_\_

Age \_\_\_\_\_

Height \_\_\_\_\_ft \_\_\_\_\_in

Current Weight \_\_\_\_\_lbs. Heaviest \_\_\_\_\_lbs. Lightest \_\_\_\_\_lbs.

Ideal \_\_\_\_\_lbs

Ethnic origin Asian Black Caucasian American-Indian Other \_\_\_\_\_

Do you form keloids or severe scars Yes / No

Where \_\_\_\_\_

Date of original scarring \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

Causes of original scars \_\_\_\_\_

Locations of scars \_\_\_\_\_

Reason for seeking scar revision \_\_\_\_\_

Previous scar treatments (with dates) \_\_\_\_\_

Previous scar surgeries (with dates) \_\_\_\_\_

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 list **ALL** other surgeries: \_\_\_\_\_

Have you ever taken any type of radiation therapy? Yes / No

What \_\_\_\_\_ When \_\_\_\_\_

Why \_\_\_\_\_

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## 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

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

## Symptoms:

- |  |                                    |  |
|--|------------------------------------|--|
| <input type="checkbox"/> Pain                              | <input type="checkbox"/> Color     | <input type="checkbox"/> Irritation          |
| <input type="checkbox"/> Itching                           | <input type="checkbox"/> Too thick | <input type="checkbox"/> Recurrent infection |
| <input type="checkbox"/> Tenderness                        | <input type="checkbox"/> Too wide  |  |
| <input type="checkbox"/> Appearance                        | <input type="checkbox"/> Too tight |  |
| <input type="checkbox"/> Restriction of activity or motion |                                    |  |

Describe \_\_\_\_\_  
\_\_\_\_\_

- Other symptoms

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_