COSMETIC MEDICAL HISTORY

Name ______________________________ Telephone Number: ______________________

Address: ______________________________ Age: __________

What is the reason for your visit today? ______________________________

Who referred you to us? ______________________________

What type of problem are you consulting for:

- □ Sun spots
- □ Wrinkles
- □ Enlarged blood vessels
- □ Flushing of the skin
- □ Large pores
- □ Other______________________________
- □ Hair removal
- □ Veins
- □ Acne Scars
- □ Uneven skin tone/texture

How many years have you noticed this problem? ______________

At what age did your skin problem begin? ______________

Are your present skin problems getting more pronounced? □ Yes □ No

Have you ever been treated for this problem? □ Yes □ No If yes, when? ______________________________

By what method? ______________________________

Who is your Primary Care Physician? ______________________________

What Pharmacy do you use? ______________________________

What is the Pharmacy's phone number and address? ______________________________

Allergies / Current Medications

Are you allergic to Latex? YES NO

Are you allergic to Lidocaine? YES NO

Any vitamins / minerals – check all that you are taking:

None
Calcium supplements
Chinese herbs
Herbal supplements
Multi-vitamin Vitamin B Vitamin C
Vitamin D Vitamin E Vitamin K

Are you allergic to aspirin? □Yes □ No Sulfur? □Yes □ No

If yes, please specify ______________________________

Do you have any drug allergies? □ YES □ NO

If yes, please list:

____

COSMETIC MEDICAL HISTORY

List all medications you are currently taking (including prescriptions, over-the-counter, vitamins, and herbals):

________________________________ ______________________________________ _____________________________

________________________________ _____________________________________ _____________________________

Past Medical History

Have you had any previous hospitalizations? If yes, explain ____

____

Please select what best describes your current general health:

Good General Health	Fevers
Recent Weight Gain	Headaches
Recent Weight Loss	Pregnant (Yes/No)
Poor Nutrition	Chronic Fatigue

Complete Past Medical History – Please Circle any that Apply:

Abnormal clotting
Abnormal menstruation
Acne
Actinic keratosis
Addison's
Alopecia
Anemia
Anticoagulation
Anxiety
Arrhythmias
Arthritis
Back pain
Basal Cell Carcinoma
Where ______________
Bipolar disorder
Bleeding ulcers
Currently breast feeding
Breast mass (left, right)
Coronary artery disease
Cancer:
Breast
Colon
Skin
Liver
Lung
CHE
Chronic edema
Chronic Fatigue
Cirrhosis
Constipation
Contact usage
Chronic obstruct. pulmonary disease
Cushings

Depression
Dermatitis
Dermatophytosis
Diabetes (diet controlled)
Diabetes (insulin depend.)
Diabetes (oral medication)
Difficult extubation
Difficult intubation
Difficulty walking
Dry eyes
Deep vein thrombosis
Easy bleeding
Eczema
Emphysema
Fibromyalgia
Gall stones
Genital warts
GERD
Hair loss
Hearing loss
Heart attack
Hemophilia
Hepatitis A
Hepatitis B
Hepatitis C
Herpes zoster
Herpes Simplex
High blood pressure
HIV
HSV I
HSV II
Hypercholesterol
Hyperthyroid

Hyperthyroidism
Hypothyroid
Incontinence
Intertriginous rashes
Irritable bowel
Jaundice
Keloid scarring
Kidney stones
Lupus
Malignant hyperthermia
Malignant melanoma
Where ________________
Migraines
Mitral valve prolapsed
Neck pain
Nipple discharge (left, right)
Onychomycosis
Oral herpes
Pacemaker
Polycystic ovary syndrome
Pulmonary embolism
Pilonidal cyst
Postop N/V
Psoriasis
Peripheral vascular disease
Pyelonephritis
Rheumatoid Arthritis
Recurrent UTI
Renal failure
Renal insufficiency
Rosacea
Squamous Cell Carcinoma
Where __________________

COSMETIC MEDICAL HISTORY

Seasonal allergies	Snoring/apnea	Varicella
Shoulder grooving	TB	Varicose veins
Shoulder pain	Telangiectasia	Venous insufficiency
Slow healing	Ulcers	Vision loss
Skin problems	Urethral structure	Warts

ANY OTHER MEDICAL PROBLEMS NOT LISTED ABOVE ____

____

Have you ever been exposed to HIV? YES NO
Explain ____

Do you have any artificial joints? YES NO
Explain ____

Have you had any allergic reactions to anesthesia? YES NO
Explain ____

Do you take antibiotics before dental work? YES NO
Explain ____

Have you ever had dental anesthesia? YES NO
Explain ____

Do you develop skin rashes to food? YES NO
Explain ____

Do you develop skin rashes to medications? YES NO
Explain ____

Do you develop skin rashes from environmental factors? YES NO
Explain ____

Do you have a history of Seizure disorder? YES NO

If Yes explain ____

Do you have any medical or skin conditions which were not listed above (please list)?

Do you wear contact lenses? □ Yes □ No

Have you had cold sores or fever blisters? □ Yes □ No

Mark your skin type (when exposed to the sun for about 1 hour with no protection):

Have you ever had skin resurfacing, rejuvenation or chemical peels? □ Yes □ No

Have you ever had treatments for pigmented lesions? □ Yes □ No

Have you been on Accutane within the past one year? □ Yes □ No

COSMETIC MEDICAL HISTORY

Past Surgical History – Please Circle all that Apply:

No Past Surgical History

FACIAL COSMETIC SURGERY
- Hair transplant
- Browlift
- Upper blepharoplasty
- Lower blepharoplasty
- Facelift
- Midface lift

HEENT SURGERY
- Cleft lip
- Cleft palate
- Intracranial surgery
- Facial fracture repair
- Lasik surgery
- RK surgery
- Ptosis correction
- Strabismus correction
- Otoplasty
- Rhinoplasty
- Septoplasty
- Thyroidectomy
- Turbinate surgery

- Tonsillectomy

BREAST SURGERY
- Breast augmentation (saline, silicone)
- Breast reduction
- Mastopexy
- Mastectomy (right, left)
- Reconstruction (implant)
- Reconstruction (TRAM)
- Reconstruction (Lat Dorsi)

TRUNK SURGERY
- Abdominoplasty
- Back surgery
- Rectus placation
- Liposuction (abdomen, chest, flanks, hips)

ABDOMINAL SURGERY
- Appendectomy
- Cholecystectomy
- Gastric bypass
- Gastric banding
- Spleenectomy
- Bowel resection
- Hernia repair

PELVIC SURGERY
- Hysterectomy
- BSO
- C-section
- Female genital surgery
- Male genital surgery

EXTREMITY SURGERY
- Hand surgery
- Carpal tunnel release
- Joint replacement
- Brachioplasty
- Liposuction (arm, medial thigh, lateral thigh, calves)
- Buttock lift
- Body lift
- Medial thigh lift
- Varicose vein surgery

Social History

Do you smoke? YES □ NO If YES, how much? ______ # packs/day
I did, but I quit _______ quitting date

Alcohol usage:
Denies Weekly 1-2 Weekly 3 or more Daily Alcoholic

Current or Past Tanning Bed usage:
Denies Weekly Monthly Past Use
When were you last exposed to the sun or a tanning booth?___________________

Do you use sunscreen?
Daily always if sunny sometimes if sunny rarely/never

Do you use chemical sun tanning lotions? YES NO
Are you planning a holiday in the sun? YES NO
What is your occupation?

____

Are you pregnant, nursing, or planning a pregnancy soon? □ Yes□ No

Birth Control Method (if applicable) ____________________________________

COSMETIC MEDICAL HISTORY

What outdoor activities do you do (check all that apply)?

- Biking
- Boating
- Fishing
- Gardening
- Golf
- Running
- Swimming
- Tennis
- Walking
- Other sports ___________________

Height:_________________ Approximate Weight:______________

Family History

	Mark YES (if no, do not mark)	Family Member (mother, father, brother, sister, etc)	Notes
Allergies			
Arthritis			
Asthma			
Cancer			
Diabetes			
Eczema			
Heart disease			
High blood pressure			
Lung disease			
Psoriasis			
Tuberculosis			

Patient's Signature _____________________________________ Date ____________________________

Parent or Guardian _____________________________________ Date ____________________________