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PATIENT MEDICAL INFORMATION

Name(print) ____ DOB___/___/_____ Age____

Reason for your visit, circle: **Cosmetic Surgery: Facelift, Lids, Brow, Liposuction, Nose, Other:**
(explain)____

____

Botox, Fillers: (Radiesse Juvederm Sculptra Voluma) Facial Rejuvenation, **Other:** ______________________________

Have you had a prior consultation? [Yes] [No] Treatment or Surgery for this condition? [Yes] [No]

Please note physician seen & when: ____

Prior Botox Fillers: [Yes] [No] Last treatment date:________________ How often:_______________

Were you referred to our office? [Yes] [No] by whom:___________________________ website social media other

<u>MEDICAL & SURGICAL HISTORY</u> *Please answer all questions!

Do you use: Tobacco [Never] [Yes] Packs per day: ___________ Discontinued when:___________

Alcohol [Yes] [No] If yes, average daily consumption:__________ Coffee/Tea:____________

PREVIOUS SURGERIES:

Please list **<u>all</u>** procedures/surgeries including Cosmetic and Implants:

____

____

Have you ever had: Epinephrine/Local Anesthesia [Yes] [No] General Anesthesia:[Yes] [No] Dental Anesthesia [Yes] [No]

Did you have a bad reaction? [Yes] [No] Please describe reaction _________________________________

<u>MEDICATIONS</u>: *If taken within the last 4 weeks

Aspirin (or meds containing aspirin)	[Yes] [No]	Insulin	[Yes] [No]
Anti-inflammatory drugs (Advil/Motrin)	[Yes] [No]	Anti-Coagulant	[Yes] [No]
Vitamin E / Herbal Supplements	[Yes] [No]	Accutane	[Yes] [No]
Oral Diabetic Medication	[Yes] [No]	Antibiotics/Tetracycline	[Yes] [No]
Birth Control/Hormone Replacement	[Yes] [No]		

All Other Medications:____

____

Please Check All that you have or had:

Cancer	[Yes] [No]	Mitral Valve Prolapse	[Yes] [No]	Psyciatric Disorder [Yes] [No]
Thyroid Disorder	[Yes] [No]	Visual problems	[Yes] [No]	Dr. Treating______________________
Leukemia	[Yes] [No]	Eye Disease	[Yes] [No]	Medications______________________
High Blood Pressure	[Yes] [No]	Myasthenia Gravis	[Yes] [No]	______________________
Heart Attack	[Yes] [No]	Bell's Palsy	[Yes] [No]	
Heart Murmur	[Yes] [No]	Stroke	[Yes] [No]	
Diabetes	[Yes] [No]	Eyelid Weakness	[Yes] [No]	
Lung Disease	[Yes] [No]	Facial Trauma	[Yes] [No]	**Allergic to or reaction to:**
Kidney Disease	[Yes] [No]	Cold Sores/Herpes	[Yes] [No]	Penicillian [Yes] [No]
Stomach/Bowel Disease	[Yes] [No]	Hepatitis A, B, C/Hiv	[Yes] [No]	Latex [Yes] [No]
Shingles	[Yes] [No]	Prolonged Bleeding/Bruising	[Yes] [No]	Albumin (eggs) [Yes] [No]

If yes to any of the above please explain____

Other medical disorders, injuries or serious illnesses requiring hospitalization (describe & year):

____

Females: Pregnant [Yes] [No] Breast Feeding [Yes] [No] Menopausal [Yes] [No]