



Health Questionnaire

Please Complete All Sections of This 4 Page Questionnaire

Patient Name:

DOB:

Skin History:

Skin Care Concerns:

- None
 Facial Veins
 Facial Redness (Rosacea)
 Acne scarring
 Facial lines or wrinkles
 Brown spots or discoloration
 Other (please specify) _____
 Uneven skin texture
 Active acne

Facial and Microdermabrasion History:

- N/A
 Past Microdermabrasions
 Never had either treatment
 Past facials and microdermabrasions
 Past Facials

Topical Skin Care History: (check all that applies)

- None
 Azelex
 Differin
 Renova
 Refissa
 Retin-A
 Tretinoin
 Tazorac
 Triluma
 Avita
 Adapalen
 Sotret
 Accutane
 Avage
 Glycolic or Alpha Hydroxy Acids
 Hydroquinone
 Other (list) _____

Herpes History:

- Never diagnosed with oral or genital herpes
 Treated for oral or genital herpes within past 2 months
 Treated for oral or genital herpes greater than 2 months ago

Facial Laser History:

- N/A
 IPL (photofacials)
 Laser resurfacing (Fraxel, Pixel, Dot, Profractional)
 Other (please list) _____
 None
 Hair laser
 Tattoo removal

Brief Eye History:

- None
 Wear contact lenses
 Elevated eye pressure or glaucoma
 Current use prescription eye medication or drops
 Wear glasses
 Chronic dry eyes or excessive tearing
 other (please list) _____

Daily Skin Regimen:

- N/A
 None
 Special soaps
 Toner
 Scrubs
 Exfoliator
 Masks
 Daily sunscreen with SPF 30 or higher
 Daily sunscreen with SPF less than 30
 Body lotions
 Facial lotions
 Other (please specify) _____

Patient Name:

DOB:

Past Medical History:

- | | |
|---|---|
| <input type="checkbox"/> Hypertension | <input type="checkbox"/> Anxiety |
| <input type="checkbox"/> Migraines | <input type="checkbox"/> Hypothyroidism |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Hyperthyroidism |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Lung Disease |
| <input type="checkbox"/> Hematologic/Blood Diseases | <input type="checkbox"/> GERD (stomach or esophagus reflux disease) |
| <input type="checkbox"/> Coronary Artery Disease | <input type="checkbox"/> Fibromyalgia |
| <input type="checkbox"/> Obesity | <input type="checkbox"/> Breast Cancer |
| <input type="checkbox"/> Neurologic Disorders | <input type="checkbox"/> Other Cancer |
| <input type="checkbox"/> Oral Herpes Simplex | <input type="checkbox"/> Chronic nonmalignant pain |
| <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Pregnancy |
| <input type="checkbox"/> Hypercholesterolemia | <input type="checkbox"/> Other (please describe) _____ |

Bleeding Problems:

- None
- Easy bleeding with cuts
- Excessive bleeding with pregnancy
- Excessive bleeding with dental work
- Taking blood thinning medications:

Pregnancy/Breast Feeding History:

- N/A
- Not currently Pregnant
- Currently Pregnant
- Not currently breast feeding
- Breast feeding:
 - never breastfed
 - breastfed one child
 - breastfed two children
 - plan breastfeeding in future
 - do not plan breastfeeding in the future
 - other(please describe) _____

Mammogram History:

<input type="checkbox"/>	N/A	<input type="checkbox"/> other (describe) _____
<input type="checkbox"/>	Never	
<input type="checkbox"/>	Within past year	

What is your current height? _____ feet _____ inches

What is your current weight? _____ lbs.

Patient Name: **DOB:**

Past Surgical / Anesthesia History:

Past Surgeries: (please check)

Non Cosmetic:	
C-section	Hysterectomy
Appendectomy	Open gallbladder
Breast biopsy	Laparoscopic gall bladder surgery
Facial trauma surgery	Breast reconstruction
Lung surgery	Hernia surgery
Intestinal surgery	Heart surgery
Tonsil or adenoid surgery	Stomach surgery
Hip replacement	Extremity surgery for trauma or injury
Knee replacement	Other (describe)
Cosmetic:	
	Rhinoplasty
Abdominoplasty	Breast augmentation
Secondary breast surgery	Upper blepharoplasty
Lower blepharoplasty	Mastopexy
Facelift	Necklift
Brow lift	Liposuction
Rhinoplasty	Cheek or chin implant surgery
Septoplasty	Other (describe)

Anesthesia complications:

- | | |
|--|---|
| <input type="checkbox"/> None | <input type="checkbox"/> Difficult intubation (placement of breathing tube) |
| <input type="checkbox"/> Difficult extubation | <input type="checkbox"/> Malignant hyperthermia |
| <input type="checkbox"/> Postoperative Nausea/vomiting | <input type="checkbox"/> Local anesthetic complications |
| <input type="checkbox"/> Allergic reaction | <input type="checkbox"/> Difficulty waking up |
| <input type="checkbox"/> sensitivity to anesthetic agent | <input type="checkbox"/> Never received general anesthesia in past |

History Non-Surgical Procedures:

Laser for blood vessels	Juvederm
Fraxel	Other fillers (describe)
Laser for sun spots	
Hair laser	Thermage
Laser for skin wrinkles	Accent
Botox	Other skin tightening procedure
Restylane	Mesotherapy
Perlane	Other (describe)

Do any medical problems run in your family? Yes No

If yes, please describe: _____

Patient Name: **DOB:**

Do you have any allergies to medications, LATEX, tape, eggs or other (please list): _____

Please list your medications that you are currently taking including all prescription and over the counter: _____

Do you take NSAIDs (such as aspirin, Aleve, motrin, ibuprofen, other) Never Rarely Weekly Daily

Do you take any herbal medications, vitamins or minerals? Yes No **If Yes, (Please list)**

Are you currently employed? Yes No **If yes, What is your occupation?** _____

Do you exercise? Yes No **If yes, please describe the type of exercise you do.** _____

If yes, how many times a week do you exercise? _____

Marital Status: Married Single Widow Widower Domestic Partner Significant other
 Separated Divorced Boyfriend Girlfriend Fiancée other

Tobacco History: Never Quit (when) _____

Currently smoke (amount) Occasional 1/2-1 ppd 1-2ppd 2-3 ppd >3 ppd

Alcohol History: never rarely 1-2 per week 3-5 per week daily

Drug History: Do you use any illicit drugs or prescription drugs not authorized by a physician?
 No Yes (please describe) _____

Active Current Medical Issues: (please check any current issues that you are dealing with)

<input type="checkbox"/>	Recent weight gain	<input type="checkbox"/>	Chronic rash or itching
<input type="checkbox"/>	Fevers	<input type="checkbox"/>	Current sores or wounds on your body
<input type="checkbox"/>	Chronic headaches	<input type="checkbox"/>	Joint pain, stiffness or swelling
<input type="checkbox"/>	Eye disease or injury	<input type="checkbox"/>	Weakness of muscles or joints
<input type="checkbox"/>	Wear glasses or contacts	<input type="checkbox"/>	Muscle pains or cramps
<input type="checkbox"/>	Blurred or double vision	<input type="checkbox"/>	Back pain
<input type="checkbox"/>	Glaucoma	<input type="checkbox"/>	Cold extremities
<input type="checkbox"/>	Chronic dry eyes	<input type="checkbox"/>	Difficulty walking
<input type="checkbox"/>	Change in bowel movements	<input type="checkbox"/>	Memory loss or confusion
<input type="checkbox"/>	Chronic nausea or vomiting	<input type="checkbox"/>	Nervousness/Anxiety
<input type="checkbox"/>	Chronic constipation	<input type="checkbox"/>	Depression
<input type="checkbox"/>	Blood in stool	<input type="checkbox"/>	Sleep problems (Insomnia)
<input type="checkbox"/>	Frequent coughing	<input type="checkbox"/>	Heart trouble
<input type="checkbox"/>	Spitting up blood	<input type="checkbox"/>	Chest pain
<input type="checkbox"/>	Shortness of breath	<input type="checkbox"/>	Sudden heart beat changes
<input type="checkbox"/>	Wheezing	<input type="checkbox"/>	Swelling of feet, ankles or legs
<input type="checkbox"/>	Blood clots	<input type="checkbox"/>	Lightheaded or dizzy
<input type="checkbox"/>	Easy bruising or bleeding	<input type="checkbox"/>	Convulsions or seizures
<input type="checkbox"/>	Anemia	<input type="checkbox"/>	Numbness or tingling sensations
<input type="checkbox"/>	Previous blood transfusions	<input type="checkbox"/>	Paralysis
<input type="checkbox"/>	Pulmonary embolism	<input type="checkbox"/>	Stroke
<input type="checkbox"/>	Frequent urination	<input type="checkbox"/>	