Health Questionnaire

Please Complete All Sections of This 4 Page Questionnaire

Patient Name: **DOB:**

Skin History:

Skin Care Concerns:

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

Facial and Microdermabrasion History:

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

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

Brief Eye History:

☐None
☐Wear contact lenses ☐Wear glasses
☐Elevated eye pressure or glaucoma ☐Chronic dry eyes or excessive tearing
☐Current use prescription eye medication or drops ☐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:

- ☐ Hypertension
- ☐ Migraines
- ☐ Asthma
- ☐ Depression
- ☐ Hematologic/Blood Diseases
- ☐ Coronary Artery Disease
- ☐ Obesity
- ☐ Neurologic Disorders
- ☐ Oral Herpes Simplex
- ☐ Mitral Valve Prolapse
- ☐ Hypercholesterolemia
- ☐ Anxiety
- ☐ Hypothyroidism
- ☐ Hyperthyroidism
- ☐ Lung Disease
- ☐ GERD (stomach or esophagus reflux disease)
- ☐ Fibromyalgia
- ☐ Breast Cancer
- ☐ Other Cancer
- ☐ Chronic nonmalignant pain
- ☐ Pregnancy
- ☐ 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:

☐	N/A	☐ other (describe)_____
☐	Never	
☐	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:

- ☐ None
- ☐ Difficult extubation
- ☐ Postoperative Nausea/vomiting
- ☐ Allergic reaction
- ☐ sensitivity to anesthetic agent
- ☐ Difficult intubation (placement of breathing tube)
- ☐ Malignant hyperthermia
- ☐ Local anesthetic complications
- ☐ Difficulty waking up
- ☐ 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 ☐ ½-1 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)

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