



### Patient Medical Information

Allergies: \_\_\_\_\_

Patient: \_\_\_\_\_ Date: \_\_\_\_\_  
Last Name First Name MI

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Gender (circle) MALE FEMALE

Occupation: \_\_\_\_\_

Emergency Contact (name/phone number): \_\_\_\_\_

Who may we thank for referring you? \_\_\_\_\_

We specialize in a number of cosmetic procedures. Are you also interested in scheduling a consultation for any of the following? PLEASE CIRCLE

YES NO Laser treatment of wrinkles, broken blood vessels or brown spots

YES NO Treatment of deep wrinkles with Collagen, Restylane, Juvederm or fat

YES NO Liposuction (Tumescent)

YES NO Eyelid lift or mini facelift for jowls and neck

YES NO Botox treatment of frown lines or crow's feet

YES NO Spider (leg) vein treatment

### Dermatology-related health questions

YES NO Previously diagnosed skin condition

Previous Dermatologist: \_\_\_\_\_

If YES, what condition(s)? \_\_\_\_\_

YES NO History of skin cancer If YES, what type? \_\_\_\_\_  
(basal cell carcinoma, squamous cell carcinoma, melanoma, other)

YES NO History of pre-cancers If YES, what type? \_\_\_\_\_  
(actinic keratoses or abnormal moles – atypical or dysplastic)

YES NO Family history of skin cancer What type? \_\_\_\_\_

YES NO Has anyone in your family had a MELANOMA? Who? \_\_\_\_\_

Skin type: FAIR MEDIUM DARK (circle one)

Ethnicity: \_\_\_\_\_

Place of Birth: \_\_\_\_\_

How many sunburns have you had since childhood? \_\_\_\_\_

Do you use sunscreen? \_\_\_\_\_

Do you work outdoors? \_\_\_\_\_

**General health questions**

Are you prone to or do you have any of the following conditions? PLEASE CIRCLE

- |                             |                                      |
|-----------------------------|--------------------------------------|
| YES NO Smoker               | YES NO Autoimmune condition          |
| YES NO Oral herpes          | YES NO Radiation treatment           |
| YES NO Tendency to bleed    | YES NO Difficulty with wound healing |
| YES NO Diabetes             | YES NO High blood pressure           |
| YES NO Heart problems       | YES NO Pacemaker/Defibrillator       |
| YES NO Psychiatric disorder | YES NO Emotional disorder            |
| YES NO Overgrown scars      | YES NO Keloid scars                  |
| YES NO Hepatitis or HIV     | YES NO Liver/Kidney disease          |

If you answered YES to any of the above questions, please explain:

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