



Confidential Health Questionnaire for Facial Treatments
Includes injections, lasers, non-surgical, & surgical procedures

Name _____ Today's Date _____

Age _____ Date of Birth _____ Email _____

Address _____ City _____ ZIP _____

Phone Number _____

Emergency Contact _____ Phone Number _____

Primary Care Physician _____ Phone Number _____

Reason for visit: _____

Which areas are of concern to you?

- Forehead
- Cheeks
- Loose skin
- Brow
- Neck
- Aging skin
- Eyelids
- Skin
- Scars
- Lips
- Nose
- Chin
- Ears
- Other _____

Past Facial Treatments

- Botox, Xeomin, Dysport
- Injections or Fillers
- Laser treatments
- Facial surgery
- Accutane
- Other _____

MEDICAL INFORMATION

Allergies

- None
- Medications _____ Reaction _____
- Environmental _____ Reaction _____
- Latex _____ Reaction _____

Medications (including dietary supplements, nonprescription and herbal products)

Past Medical History (list any past or current medical problems)

Cold sores or herpes infections

Past Surgical History (list any past procedures & operations, including complications)

Implant, pacemaker, defibrillator, or implantable medical device

Social History

Current Occupation _____

Do you smoke or use tobacco? No Yes

Packs per day _____

Year started _____ Year stopped _____

Do you drink alcohol? No Yes

Drinks per week _____

Do you use recreational drugs? No Yes

Marital Status: Married Single Widowed

Number of children _____

Will any dependents rely on you after surgery? _____

Are you planning on having more children? _____

Who will care for you after surgery? _____

Loss of pregnancies or spontaneous abortions _____

Family Medical History (please explain if any of these conditions have affected a blood relative)

- Cancer
- Breast Disease
- Heart disease (heart attacks, heart bypass surgery)
- Abnormal reaction to anesthesia

Bleeding or Blood Clotting Disorders

Have you or any blood relative had problems with:

- Abnormal or excessive bleeding
- Abnormal or excessive blood clotting, also called Deep Venous Thrombosis (DVT) or Pulmonary Emboli (PE)

Do you have now, or have you been diagnosed as having (if yes, please explain)

- | | |
|--|--|
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Stomach or duodenal ulcer |
| <input type="checkbox"/> Thyroid disease | <input type="checkbox"/> Stomach or intestinal bleeding |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Irregular or rapid heart beat |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> High blood pressure |
| <input type="checkbox"/> Cancer or tumor | <input type="checkbox"/> Frequent gum or nose bleeds |
| <input type="checkbox"/> Diabetes mellitus | <input type="checkbox"/> Angina or chest pain |
| <input type="checkbox"/> Heart attack | <input type="checkbox"/> Jaundice or liver disease |
| <input type="checkbox"/> Heart failure | <input type="checkbox"/> Mood disturbance |
| <input type="checkbox"/> Kidney disease | <input type="checkbox"/> Heart murmurs |
| <input type="checkbox"/> Easy bruising | <input type="checkbox"/> Shortness of breath or wheezing |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Frequent heartburn or reflux |
| <input type="checkbox"/> Varicose veins | <input type="checkbox"/> Fainting or dizziness |
| <input type="checkbox"/> Seizures | <input type="checkbox"/> Nervous breakdown |
| <input type="checkbox"/> Palpitations | <input type="checkbox"/> AIDS or HIV positive |
| <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Immune disorders |
| <input type="checkbox"/> Hernia | |

Height _____ **Weight** _____ lbs

How did you hear about our practice?

- | | | | |
|--|-----------------------------------|---|--------------------------------------|
| <input type="checkbox"/> Internet search | <input type="checkbox"/> Doctor | <input type="checkbox"/> Friend | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Television | <input type="checkbox"/> Magazine | <input type="checkbox"/> Web site _____ | |

Who can we thank for this referral? _____

Completed by _____ **Signature** _____

Section below to be completed by physician

Fitzpatrick _____

Ethnicity _____

Impression:

Recommendations:

Signature _____

Date _____