Cosmetic Medical History

Name:____ **Date:**______________

Areas of Cosmetic Concern:

Which of the following areas of the face, neck and body are of the most cosmetic concern to you and what treatments are you interested in? (**circle those most important to you and indicate concern**):

Face: ____

Saggy neck: ____

Eyes: ____

Droopy or baggy eyelids: ____

Saggy Brow: ____

Nose: ____

Cheeks: ____

Chin: ____

Skin: ____

Blotchy Skin: ____

Jowls: ____

Breasts: ____

Body Trunk Legs Arms: ____

Abdomen: ____

Love handles: ____

Thighs: ____

Cosmetic Procedures Considering:

Facelift Surgery: ____

Eye lift, Brow Lift: ____

Fat transfer & fillers: ____

Botox: ____

Laser hair removal: ____

Body Trunk, Legs Arms Liposuction: ____

Motivation: What motivation best describes your motivation for seeking aesthetic procedures, circle all that apply:

1) Feel better about myself
2) More competitive in the workplace
3) Restarting the dating scene
4) Spouse or partner wants me to do it
5) Someone pointed out the aging area and I now feel self-conscious
5) Very concerned about the appearance of the specific area of concern
6) Depressed about my life need a change
7) Want to feel more youthful and vibrant
8)I hate the way I look

Please answer the following Questions:

Question			Question		
Is walking up a flight of stairs with a bag of groceries difficult for you?	Yes	No	Kidney Insufficiency?	Yes	No
Are you currently pregnant?	Yes	No	Liver insufficiency, cirrhosis, hepatitis?	Yes	No
Are you currently undergoing radiation therapy or chemotherapy for cancer?	Yes	No	Blood clots or Pulmonary Embolism?	Yes	No
Have you ever had a connective tissue disorder such as Ehlers Danlos Syndrome, Lupus, Scleroderma, Rheumatoid Arthritis, Wegener's Disease or Sarcoidosis?	Yes	No	Diabetes that requires medication?	Yes	No
Have you had surgery of the face or neck within the previous 6 months?	Yes	No	High Blood Pressure (hypertension)?	Yes	No
Oxygen dependent COPD or severe asthma?	Yes	No	Heart disease or heart problems?	Yes	No
Bleeding Disorder?	Yes	No	Have you ever had an aortic aneurysm?	Yes	No
Abnormal Scarring?	Yes	No	Angina or chest pain w/exercise?	Yes	No
Reaction to latex?	Yes	No	Angioplasty and/or stent placement?	Yes	No
Lidocaine allergy?	Yes	No	Have you had a heart attack within the past 12 months?	Yes	No
Epinephrine sensitivity?	Yes	No	Do you have a pacemaker or AICD?	Yes	No
Currently taking Coumadin, Aspirin, Plavix, Pradaxa or other anticoagulant (blood thinner)?	Yes	No	Heart Catheterization/stress test? Date: ____________________ Normal ______ Abnormal_____	Yes	No
Brain aneurysm or brain shunt?	Yes	No	Have you ever had a stroke or TIA?	Yes	No
Prior parotidectomy (salivary gland removal)?	Yes	No	Are you a current smoker?	Yes	No
OBSTRUCTIVE SLEEP APNEA?	Yes	No	Severe dry eyes?	Yes	No
Do you have Restless Leg Syndrome?	Yes	No	Limited Neck mobility?	Yes	No
HIV/AIDS?	Yes	No	Have you taken the medication Accutane within the past 12 months?	Yes	No
Do you consume more than 2 alcoholic drinks per day on average?	Yes	No			

If you answered yes to any of the above, provide details, and indicate the name of the specialist treating this condition:

____

____

____

____

____

PLEASE ANSWER ALL OF THE QUESTIONS BELOW:

PAST MEDICAL HISTORY:
AGE: ______________________ **DATE OF BIRTH:** ________________
WEIGHT: __________________ **HEIGHT:** __________________________
SEX: ______________________ **RACE:** ____________________________
OCCUPATION: ____
Please list all <u>MEDICAL</u> problems:
____
____
____
____
____
____

Prior <u>HOSPITALIZATIONS</u> for medical reasons:
Problem *Date* *Hospital*
____
____
____

Prior <u>SURGERIES</u>:
Surgery *Date* *Hospital*
____
____
____
____

Prescription <u>MEDICATIONS</u> presently taking:
Name *Dose* *Frequency*
____
____
____
____
____
____
____

Do you take Aspirin or Ibuprofen? (Please circle) Yes, No

All personal <u>PHYSICIANS</u> seen in the last 5 years:
Name *Type of physician* *Reason for seeing*
____
____
____
____

List all <u>ALLERGIES</u> to medication:
Medication *Type of reaction*
____
____
____

<u>TOBACCO</u> use in the past:
Present day tobacco use? Yes No (circle)
Packs per day? _____; *Total # of years smoking?* ___________
Did you use to smoke years ago and quit? <u>Yes</u> <u>No</u> (circle)
If yes, how many years since you have smoked? __________

<u>Alcohol</u> use in the past:
Alcohol use? <u>Yes</u> <u>No</u> How many drinks per day? ______

Any chance you could be <u>PREGNANT?</u> *<u>Yes</u> <u>No</u> <u>N/A</u> (circle)*

Last <u>TETANUS</u> shot: *Date:* ____________________

<u>FAMILY HISTORY:</u>
Age(s) *Medical Problems*
Father: ____
Mother: ____
Brothers: ____
Sisters: ____
Grandfathers: ____
Grandmothers: ____

Please Circle All That Apply (Most Current)

CONSTITUTIONAL:
1. Fatigue
2. Fever
3. Night Sweats
4. Weight Gain
5. Weight Loss

EYES:
6. Blurred Vision
7. Double Vision

EARS:
8. Ear Pain
9. Ear Drainage
10. Hearing Change/Loss
11. Ringing/Head Noise
12. Dizziness/Imbalance
13. Ear Infection

NOSE:
14. Runny Nose
15. Stuffiness/Nasal Congestion
16. Bloody Nose
17. Nasal Obstruction
18. Sinusitis/Sinus Infection
19. Previous Nasal Fracture

THROAT:
20. Snoring
21. Difficulty Swallowing
22. Voice Problems
23. Post Nasal Drainage
24. Cough

RESPIRATORY:
25. Coughing Blood
26. Pain with Breathing
27. Shortness of Breath
28. Wheezing

CARIOVASCULAR:
29. Chest Pain
30. Rapid/Irregular Heart Beats

PSYCHIATRIC:
31. Depression
32. Hallucinations
33. Mood Changes
34. Sleep Disturbance
35. Stress

GENITO/URINARY:
36. Difficulty Urinating
37. Frequency Urination

GASTRO/INTESTINAL:
38. Appetite/Weight Change
39. Blood in Stool
40. Bowel Problems
41. Diarrhea
42. Heartburn

NEUROLOGIC:
43. Clumsiness
44. Convulsions
45. Headache
46. Memory Problems
47. Migraine
48. Numbness
49. Seizures

Family Physician Name: ________________________ Phone Number ________________________Date of last exam: ___________________

Cardiologist's Name: ___________________________ Phone Number ________________________Date of last exam: ___________________

I certify that I have listed completely my medical conditions, medications, allergies, hospitalizations, surgeries, to the best of my knowledge and ability.

Signature: ____ Date:_____________