Cosmetic Consultation and Medical Questionnaire

Today's Date: _____

Name: _____Date of Birth:____/____/___
Gender: _____ Height: _____ Weight: _____
Home Telephone: ( ) _____ Cell Phone: ( ) _____
Home Address: _____ City: _____
State: _____ Zip: _____
E-mail address:_____
Occupation: _____

How would you like us to confirm your appointments?
[ ] TEXT MESSAGE [ ] EMAIL

How did you hear about us?
□ Friend/Family _____□ Gift Certificate □ Search Engine (Google, Yahoo, MSN) □ Walk In □ Social Media □ Product website:_____
□Organization_____□Event_____□Other_____

List ALL Cosmetic Procedures you have had (Botox, Lasers, Injectable Fillers, Peels, microneedling, PRP, other…)

Procedure	Year	Doctor/Spa	Location

Were there complications? (If yes, please explain)
[ ] Yes [ ] No
_____

Did you have a normal recovery? (If no, please explain)
[ ] Yes [ ] No

_____

Were you satisfied with the results? (If no, please explain)
[ ] Yes [ ] No

_____

List Medical Conditions (Hypertension, Diabetes, Cancer)

_____

_____

List Surgeries, including cosmetic (breast augmentation, face lift, eyelid surgery, etc.)

_____

_____

Are you currently under the care of a physician for a medical/surgical/psychiatric problem? Explain:

_____

_____

Who Is Your Doctor?_____

Are you taking any medications: [ ] Yes [ ] No
Please list any prescription or over-the-counter medication regularly or occasionally taken (including aspirin, Advil, vitamins. etc)?

_____

_____

Do you take aspirin or blood thinners? [ ] Yes [ ] No list: _____

Are you taking or have you taken Acutane?
[ ] Yes [ ] No When?_____

Are you using a topical prescription vitamin A? (Tretinoin, Retin A, Retinoic Acid, Tazorac, Differin, Renova, etc.) YES[ ] NO [ ] list_____

Have you used a tanning bed or been sun bathing in the last week? [ ] Yes [ ] No
Are you using Glycolic Acid/Hydroxy Acid [ ] Yes [ ] No

Are you on hormone replacement therapy? [ ] Yes [ ] No
Do you take birth control pills? [ ] Yes [ ] No
Do you have skin discoloration? (Melasma, light, brown, red, or dark areas)
[ ] Yes [ ] No
Do you use sunscreen? [ ] Yes [ ] No
Are you currently under a physician's care for a skin care condition? Explain:

_____

Allergies to Medication: [ ] Yes [ ] No
Are you allergic to any medication, aspirin, antibiotics, latex etc.? (If yes, please list and explain reaction):

_____
Have you ever had an allergic reaction to any skin product or cosmetic?
[ ] Yes [ ] No
Explain:

_____

Other Allergies: (fruit, seafood, eggs, cosmetics)

_____

Have you had a "reaction" to any anesthetic (Novocaine/Lidocaine) administered by a dentist or doctor? [ ] Yes [ ] No explain: _____

Women:
Do you have polycystic ovary disease? [ ] Yes [ ] No
Is there any possibility that you are pregnant? ? [ ] Yes [ ] No

What is your ancestry? (Irish, English, African, Latin, Indian, Asian, etc.)

_____

List the skin care products you currently use both over the counter and prescription: [ ] Yes [ ] No

_____
_____

Have you had an injury, to the face, nose, neck, or eyes?
[ ] Yes [ ] No
(If yes, when? And explain)_____

Do you smoke? [ ] Yes [ ] No
If yes, number of packs per day_____ for how long _____

Do you drink any alcoholic beverages? [ ] Yes [ ] No
Number of drinks per day/week _____

Do you exercise regularly? [ ] Yes [ ] No

Have you ever had a cold sore, shingles, or herpes? [ ] Yes [ ] No

Have you had permanent cosmetics done? [ ] Yes [ ] No, explain: _____

Do you have tattoos? [ ] Yes [ ] No, location: _____

Please answer the following:
I accept the fact that there are risks involved in every cosmetic procedure
[ ] Yes [ ] No

I am aware that the possibility exists that my cosmetic treatments may not fully meet my expectations [ ] Yes [ ] No

I understand that results of my cosmetic treatment are dependent upon full and complete disclosure of all medical and surgical information pertaining to me; and, that omission of issues relating to my health, past surgical history, current medications and allergies, or any other pertinent information may directly affect my personal safety and/or results; and I will follow my post care instructions
[ ] Yes [ ] No

Patient signature_____Date :_____

Physician signature_____Date:_____