MEDICAL QUESTIONNAIRE (CONFIDENTIAL)

NAME:_____ Date_____
Birthdate_____ Age_____ Occupation_____

MEDICAL HISTORY: Please describe the main reason(s) for your visit/referral:
(For each condition, if possible or pertinent, please include how long you have been afflicted,
whether or not the condition is symptomatic (e.g. itchy or painful),
any perceived aggravating or alleviating factors, past and current treatment(s)
and whether treatment(s) was/is successful and any other current possibly related conditions)

_____
_____
_____
_____
_____

Are you ALLERGIC to any medications? ❑ YES ❑ NO
If YES, please indicate which one(s):_____

Are you ALLERGIC to any foods? ❑ YES ❑ NO
If YES, please indicate which one(s):_____

Are you ALLERGIC to any other environmental exposures? ❑ YES ❑ NO
If YES, please indicate which one(s):_____

Please list all MEDICATIONS that you are currently taking, (including birth control pills,
over the counter medications and any medications that you take occasionally).

_____
_____
_____

How much ALCOHOL do you consume in a week?_____
How much TOBACCO do you consume in a week?_____
Have you traveled out of state recently? ❑ YES ❑ NO
If YES, where_____

Do you have any first degree relative(s) with any inherited skin conditions? ❑ YES ❑ NO
If YES, which relative(s), age of onset, what condition(s)_____
or skin cancer? ❑ YES ❑ NO
If YES, which relative(s), age, what type(s)_____
Do other family members have skin problems now or in the past? ❑ YES ❑ NO
If yes, which family member(s) and describe problem(s):_____
_____
Please indicate any other diseases/conditions of your first degree relatives.
Parents (Father & Mother):_____
Siblings:_____
Children:_____

When exposed to sunlight, do you: ❑ Burn ❑ Burn-Tan ❑ Tan
Have you ever had a skin cancer? ❑ YES ❑ NO
If YES, what type(s), location(s), treatment method(s), and year(s) treated:
_____
Do you have a personal history of any specific skin diseases? ❑ YES ❑ NO
If YES, please list_____
_____

Do you have or have you been previously diagnosed with, treated for or received any of the following:

	YES	NO		YES	NO
Recent Fever	❑	❑	X-ray or Radiation Treatments	❑	❑
Recent significant Weight Loss	❑	❑	PUVA or UVB	❑	❑
Heart Disease	❑	❑	Diabetes	❑	❑
High Blood Pressure	❑	❑	Glaucoma	❑	❑
Angina/Chest pain or Heart Attack	❑	❑	Hepatitis or Yellow Jaundice	❑	❑
Heart Rhythm Disturbance	❑	❑	Blood Transfusions	❑	❑
Pacemaker	❑	❑	IV or Recreational Drug Use	❑	❑
Stroke / TIA / Carotid artery disease	❑	❑	AIDS or HIV	❑	❑
Seizure or Epilepsy	❑	❑	Problems Healing	❑	❑
Bronchitis or Emphysema	❑	❑	Excessive Scarring	❑	❑
Hay Fever or Asthma	❑	❑	Liver Disease	❑	❑
Other Breathing Difficulty	❑	❑	Kidney or Bladder Disease	❑	❑
Chronic or Morning Cough	❑	❑	Intestinal colitis or Chron's dis.	❑	❑
Bleeding Disorder	❑	❑	Other Stomach/Bowel Disease	❑	❑
Cold Sores or Fever Blisters	❑	❑	Thyroid Disease	❑	❑
Heart Murmur	❑	❑	Rheumatoid Arthritis	❑	❑
Mitral Valve Prolapse	❑	❑	Lupus erythematosus	❑	❑
Artificial joint	❑	❑	Scleroderma	❑	❑
Phlebitis (Inflammation of vein/s)	❑	❑	Other Collagen-vascular dis.	❑	❑
Blood clots (esp, deep vein or lung/s)	❑	❑	Vision &/or hearing deficits	❑	❑
Peripheral vascular disease	❑	❑	Nasal symptoms / sore throat	❑	❑
Dizziness or Fainting	❑	❑	Abdominal pain	❑	❑
Emotional Problems	❑	❑	Urinary discomfort	❑	❑
Chronic fatigue	❑	❑	Muscle &/or joint pain	❑	❑

(Women) Are you currently **PREGNANT** or **NURSING**? ❑ ❑
or are you trying to get **PREGNANT**? ❑ ❑

Are your Vaccinations/Immunizations up to date? ❑ ❑
Do you take antibiotics routinely before dental check-ups or surgery? ❑ ❑
Other Illnesses/injuries/conditions?_____
_____
Please list previous hospitalizations/surgeries including year and reason:_____
_____

If you are here for a COSMETIC Surgery Consultation, please also answer the following questions:
Do you use or have you ever used any of the following products:
❑ Retin-A, Renova, or Tretinoin (What type/strength_____)
❑ Alpha-hydroxy acid or glycolic acid product (Which one(s)?_____)
❑ Hydroquinone product (Bleaching or fading cream) (Which one(s)/how long?_____)
Any other product(s) that you think we should know about?_____
❑ Accutane (Isotretinoin)/Sotret/Amnesteem/Claravis or Soriatene (Please describe use history_____
_____)
Have you been previously diagnosed with, treated for or received any of the following:

	YES	NO		YES	NO
Collagen (Type_____)	❑	❑	Dry eyes	❑	❑
Restylane / Perlane / JuveDerm	❑	❑	Eye disease or surgery	❑	❑
Artefill / Radiesse / Sculptra	❑	❑	Neuromuscular disease	❑	❑
Facial Electrolysis	❑	❑			

Please list previous Cosmetic surgeries or procedures not already mentioned (Type, When, by Whom):
_____
_____

SIGNATURE_____ DATE_____