Medical History Intake Questionnaire

Date of Consultation: _____

Patient Name: _____

Whom may we thank for this referral? _____

What concern or problem brings you to our office? _____

Physician Care
Primary Care Doctor: _____

Referring Doctor: _____

Dermatologist: _____

Past Medical History	**Yes**		**Yes**		**yes**
Allergies		Stroke		Hypertension	
Anemia		COPD		Irritable Bowel Disease	
Angina (chest pain)		Coronary Artery Disease		Liver Disease	
Anxiety		Crohn's Disease/Ulcerative colitis		Migraines	
Arthritis		Depression		Heart Attack	
Asthma		Diabetes		Osteoarthritis	
Heart Arrhythmia		Gall Bladder Disease		Osteoporosis	
Autoimmune disorder		GERD		Kidney Disease	
Blood Clots		Hepatitis/HIV		Seizure Disorder	
Cancer		Herpes/Fever Blisters/Shingles		Thyroid Disease	

Please add additional details if answered "yes" to above: _____

_____

Are you pregnant or lactating? _____
Have you ever been diagnosed or treated for a psychiatric condition? _____
Do you have any problems with wound healing/keloid formation? _____

Medications (include vitamins & supplements)	**Medication Allergies**

Are you allergic to Latex? Yes/ No
Are you taking blood thinners (Coumadin/Plavix/Xarelto/Eliquis/Aspirin/NSAIDS) Yes/ No
Have you taken Accutane? Yes/ No
If yes, when did you discontinue? _____
Do you use any Retinol/Retin-A products? Yes/ No
Do you smoke? Yes/ No
Did you ever smoke? Yes/ No

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If yes, when did you quit? _____

Review of Systems	**Yes**		**Yes**		**Yes**
Chills		Cough		Dizziness	
Fatigue		Shortness of Breath		Headaches	
Fever		Chest Pain		Memory loss	
Malaise		Edema		Anxiety	
Weight gain		Abdominal pain		Depression	
Vision changes		Diarrhea		Insomnia	
Hearing loss		Constipation		Contact allergy	
Nasal drainage		Nausea		Skin Lesions	
Sinus Pressure		Vomiting		Back or joint pain	
Sore throat		Bleeding or bruising tendencies		Urinary problems	

If you answered "yes" to any of the above, please give additional information: _____

Please list any past surgeries (including cosmetic surgeries) Date of Surgery

Have you had any facial aesthetic procedures?

Neurotoxin (Botox, Dysport) Yes/ No

Dermal Filler (Juvaderm, Restylane, etc,) Yes/ No

Facial implants (lip, cheek, chin) Yes/ No

Have you ever had any reactions/problems with above treatments? Yes/ No

If you answered "yes" to any of the above, please give additional details: _____

_____

Additional procedures or products of interest to you (please check all that apply):

☐ Latisse® Eyelash Growth Product

☐ BotoxCosmetic®Dysport®Xeomin®

☐ Juvaderm®Restalyne®Radiesse®Injectable fillers

☐ Skin care advice/skin care products

☐ Facial treatments/microneedling/IPL/Infini RF/CO2 laser resurfacing

☐ Kybella

Patient Signature: _____ Date: _____