NEW IMAGE
PLASTIC SURGERY

PATIENT HISTORY

Patient Name: _____ Date: _____

Date of Birth: _____ Occupation: _____

Address: _____

Cell Phone: _____ Home Phone: _____

Emergency Contact Name and Phone: _____

MEDICAL HISTORY

Do you have any of the following medical conditions (please check those that apply):

- ☐ Cardiac Problems (e.g. pacemaker or defibrillator)
- ☐ Bleeding Disorders (bruise easily)
- ☐ Daily use of anticoagulants or aspirin
- ☐ Diseases stimulated by light (e.g. Epilepsy)
- ☐ Diseases stimulated by heat (Herpes Simplex)
- ☐ Skin disorders or skin lesions
- ☐ Hormone Imbalance (e.g. PCO)
- ☐ Melasma/PIH
- ☐ Autoimmune disorder (e.g. Lupus, HIV/AIDS)
- ☐ High Blood Pressure
- ☐ Keloids/Scarring
- ☐ Impaired Healing
- ☐ Cancer
- ☐ Frequent cold sores
- ☐ Diabetes
- ☐ Hepatitis
- ☐ Thyroid Disorder

Please explain if you checked any of the above: _____

MEDICATIONS

Have you ever use Accutane for acne treatments? ☐ No ☐ Yes Dates Used: _____

Please list all prescription medications you are currently taking: _____

Please list all OTC medications and supplements you are currently taking: _____

Have you ever had an allergic reaction to the following (please check those that apply):

☐ Latex ☐ Lidocaine ☐ Anesthesia ☐ Topical Anesthetic ☐ Other

Please explain: _____

Female Patients: ☐ Are you pregnant? ☐ Are you breast feeding?

Surgical History (including cosmetic) – Please list all surgeries and the year that they were performed:

Cosmetic Treatment History – Please list all treatments and the year that they were performed:

Are you under the care of a physician or dermatologist at this time? ☐ Yes ☐ No

Do you smoke? ☐ Yes ☐ No Do you drink alcohol? ☐ Yes ☐ No

SKIN TYPE

Ethnicity: Please check all the apply (even if you are a combination of the below)

☐ White ☐ Asian ☐ Mediterranean ☐ Black ☐ Hispanic ☐ Middle Eastern

Which of the following describes best your skin reaction when you are in the sun?

☐ Always burn, never tan (Type I)
☐ Burn easily, tan minimally (Type II)
☐ Burn and tan moderately (Type III)
☐ Rarely burn, tan easily (Type IV)
☐ Rarely burn, tan profusely (Type V)
☐ Never burn, tan profusely (Type VI)

Are you tan now? ☐ No ☐ Yes ☐ From sun ☐ From tanning bed ☐ From tanning lotion

Will you be exposed to the sun in the near future? ☐ Yes ☐ No

Do you use sunscreen? ☐ Never ☐ Sometimes ☐ Always

What SPF do you use? How often do you apply your sun screen during the day? _____

_____

Do you have any problems with hyperpigmentation (dark skin coloration) or hypopigmentation (light skin discoloration)? ☐ No ☐ Yes Location: _____

What skin care products do you use? _____

_____

Have you had any injections or fillers in the area to be treated? If so, please specify: _____

_____

Do you have any tattoos (including permanent makeup)? ☐ No ☐ Yes

If yes, please specify the location: _____

_____

Do you have any moles, birthmarks, or any other dark lesions? ☐ No ☐ Yes

If yes, please specify the location: _____

_____

When were these lesions last checked by a physician? _____

_____ _____

Patient Signature Date

Disclaimer: This clinical form is presented for information purposes only. This document cannot and should not be used as a basis of diagnosis or choice of treatment, and is not intended to replace profesasional medical care or attention by a qualified practitioner.

NEW IMAGE
PLASTIC SURGERY