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**Cosmetic Medical History**

All questions contained in this questionnaire are strictly confidential and will become part of your medical record. All questions must be answered. Failure to do so will result in an inaccurate medical record and may affect your insurance processing. PLEASE ASK if you have any questions.

**Date:** \_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

**Your Name: (Last, First, MI**)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date of Birth**:\_\_\_/\_\_\_\_/\_\_\_\_\_ **Age:** \_\_\_\_\_

**How do you identify yourself: (Place an “X”) Male**\_\_\_\_\_ **Female** \_\_\_\_\_ **Other**\_\_\_\_\_\_

**Pharmacy – Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Location: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**PLEASE CIRCLE BELOW ALL MEDICAL DIAGNOSES YOU HAVE:**

|  |
| --- |
| **PAST MEDICAL HISTORY** |
| Diabetes | Heart Disease/Congestive Heart Failure | Hepatitis/Liver Disease | Hypertension (high blood pressure  | Kidney Disease |
| Migraines | Lung Disease | B12 deficiency | Restless Legs | HIV |
| Arterial Disease | Stroke | Cancer | Hole in your heart (Patent Foramen Ovale) | Pacemaker  |
| Anemia | Lymphedema | Asthma | Arthritis | OTHER:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**PLEASE CIRCLE THE ANSWER THAT FITS YOU – FEMALES ONLY:**

|  |
| --- |
| **PAST MEDICAL HISTORY: PREGNANCY/NURSING HISTORY**  |
| **QUESTION** | **ANSWERS** |
| 1. **Are you nursing?**
 | Yes | No |  |
| 1. **Are you planning more children?**
 | Yes  | No |  |
| 1. **Are you Pregnant?**
 | Yes | No | **If yes, which Trimester?** | First | Second | Third  |
| 1. **How many pregnancies have you had?**
 | #\_\_\_\_\_\_\_\_ | **How many C-sections?** | **#\_\_\_\_\_\_\_\_** | **How many Vaginal Deliveries?** | **#\_\_\_\_\_\_\_** |  |
| 1. **Have you had a blood clot from pregnancy?**
 | Yes | No  |  |  |  |  |
| 1. **Are you taking birth control pills?**
 | Yes | No | **If no, have you taken them in the past?**  | Yes | No |  |
| 1. **Are you taking Hormone Replacement Therapy?**
 | Yes | No | **If no, have you taken them in the past?**  | Yes | No |  |

**PLEASE CIRCLE ALL THE CONDITIONS/SURGERIES YOU HAVE HAD (FEMALE CONTINUED):**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Fibroids  | Endometriosis | C-Section | Hysterectomy | Ovary Removal |
| Ovarian Cysts | Myomectomy | Uterine Ablation | OTHER: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

|  |
| --- |
|  **PAST SURGERIES – NON VEIN** |
| **SURGERY** | **YEAR** |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  **PAST VEIN SURGERIES** |
| **SURGERY (STRIPPING, LASER, ETC.)** | **YEAR** |
|  |  |
|  |  |
|  |  |

**PLEASE PLACE AN “X” IN THE ANSWER THAT FITS YOUR FAMILY:**

|  |
| --- |
| **FAMILY HISTORY FOR VENOUS DISEASES** |
| **CONDITION** | **MOTHER** | **FATHER** | **BROTHER**  | **SISTER** | **OTHER FAMILY** |
| **Rosacea** |  |  |  |  |  |
| **Acne** |  |  |  |  |  |
| **Melanoma or skin cancers** |  |  |  |  |  |

**PLEASE FILL IN THE BLANKS AND CIRCLE THE ANSWER THAT FITS YOU:**

|  |
| --- |
| **SOCIAL HISTORY** |
| 1. **OCCUPATION:**
 |  |
| 1. **Are you retired?**
 | Yes | No  |  |
| 1. **Do you drink alcohol?**
 | Yes | No | **If yes, how many times have you had more than 4 drinks in one day in the past year?**  | \_\_\_\_\_# of times more than 4 drinks in one day |  |
| 1. **Do you smoke?**
 | Yes | No | **If yes, do you smoke: (circle)** | less than 9 cig/day | Greater than 10 cig/day |
| 1. **Do you use chewing tobacco?**
 | Yes | No |  |  |  |
| 1. **If you smoke:**
 | **What age did you start?** **age\_\_\_\_\_\_** | **How many packs per day? \_\_\_\_packs/day** | **Have you thought about quitting?**  | Yes  | No |
| 1. **If you are a FORMER Smoker:**
 | **How long did you smoke?****\_\_\_\_\_\_years** | **At what age did you start?** **age\_\_\_\_** | **How packs per day?****\_\_\_packs/day** |  |  |
| 1. **Marital Status?**
 | Married  | Unmarried | Divorced  | Widowed | Other\_\_\_\_\_\_\_\_ |
| 1. **Do you have children?**
 | Yes | No  | **If yes, how many children? \_\_\_\_\_\_\_** |  |  |

|  |
| --- |
| **CURRENT MEDICATIONS (please include all over the counter and supplements)** |
| **Name** | **Strength** | **Frequency (how often)** |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

|  |
| --- |
| **ALLERGIES** |
| **Medication/Food** | **Type of reaction (rash, hives, etc.)** | **CIRCLE severity of reaction** |
|  |  | mild moderate severe |
|  |  | mild moderate severe |
|  |  | mild moderate severe |
|  |  | mild moderate severe |

**FITZPATRICK CLASSIFICATION SYSTEM (Please check which applies)**

**Skin Type Skin Color Characteristics**

\_\_\_\_ I White Always burns, never tans

\_\_\_\_ II White Usually burns, never tans

\_\_\_\_III White Sometimes mild burn, tans about average

\_\_\_\_ IV White Rarely burns, tans more than average

\_\_\_\_ V Brown Rarely burns, tans perfectly

\_\_\_\_ VI Black Never burns, deeply pigmented

**SKIN TYPE:**

Does your skin ever flake or feel tight and dry? Frequently Occasionally Rarely

Is your skin shiny a few hours after cleansing? Frequently Occasionally Rarely

How often do you experience blackheads or blemishes? Frequently Occasionally Rarely

How noticeable are your pores? Very Not Very

**For Microdermabrasion/HydraFacial:**

Have you seen a dermatologist for your skin? [ ]Yes [ ]No

Have you ever had laser surgery, microdermabrasion or peels? [ ]Yes [ ]No If so, when? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What type of skin products are you using now? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever had Botox/Collagen fillers? [ ]Yes [ ]No If so, when? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever had skin cancer? If yes, where and what treatments? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**For Hair Reduction/Electrolysis:**

What color is the hair of concern: \_\_\_\_\_\_\_\_\_ What area needs treatment: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you shave? [ ]Yes [ ]No Do you pluck? [ ]Yes [ ]No Do you use a cream for hair removal? [ ]Yes [ ]No

**For any skin conditions (redness, rosacea, pores, wrinkles, etc.):**

Do you have rosacea? [ ]Yes [ ]No If yes, what have you tried and for how long? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have acne? [ ]Yes [ ]No Is it cystic? [ ]Yes [ ]No Do you have scars? [ ]Yes [ ]No

What have you tried in the past?(creams, prescriptions, treatments, etc.)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What are you concerned about with your skin? (wrinkles, pores, dryness, oily, etc.)\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What current products do you use on your skin (face wash, creams, etc – prescription and over the counter): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**For Tattoo Removal:**

When did you get your tattoo? \_\_\_\_\_\_\_\_\_\_\_ Location(s) on body of tattoo to be removed \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please circle Yes/No:**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Black Tattoo | Yes | No | Keloid Scars | Yes | No | Tanning within the last 6 weeks | Yes | No | Did you have an allergic reaction to your tattoo? | Yes | No | Hypersensitivity to skin products | Yes | No |
| Color Tattoo | Yes | No | Hives | Yes | No | Use of acne products/drugs | Yes | No | Steroid use? | Yes | No | Skin infections | Yes | No |
| Professional Ink | Yes | No | Skin Cancer | Yes | No | Photo sensitizing substances | Yes | No | Any Previous Tattoo Removal | Yes | No | Homemade Ink | Yes | No |
| Waxing | Yes | No | Cold sores | Yes | No | Needle phobia? | Yes | No | Autoimmune medications?  | Yes | No | Electrolysis to area | Yes | No |

**For Microneedling with Radiofrequency (Secret RF):**

What are your concerns? Acne, pores, wrinkles, scars, etc. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What other treatments have you have had to address your concerns? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have a pacemaker? Yes or No (Circle one)

Have you had microneedling done before or do you use a device at home? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you want Nitrous for your treatment? ($25 additional) Yes or No (Circle one)

**For TruSculpt Treatments:**

Are you looking for fat reduction or muscle building? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Areas you would like treated? Please circle below:

|  |  |  |  |
| --- | --- | --- | --- |
| Lower Abdomen | Upper Abdomen | Right Flank | Left Flank |
| Back | Bra Bulge | Arms | Front of Legs |
| Back of Legs | Inner Thighs | Outer Thighs | Buttocks |

Have you had treatments to these areas before? If yes, when: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Thank you for providing this important information about your medical history. Please be advised that completing preliminary health and insurance questionnaires does not establish a physician-patient relationship with this practice. Dr. Aggarwal and the staff will review your health history and conduct an initial evaluation to determine whether you are a suitable candidate and whether the practice will accept you as a patient.

Responsible Party Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to Patient (if other than self): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Notes:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**