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				
2. Are you planning more children?	Yes	No				
3. Are you Pregnant?	Yes	No	**If yes, which Trimester?**	First	Second	Third
4. How many pregnancies have you had?	#________	**How many C-sections?**	#________	**How many Vaginal Deliveries?**	#_______	
5. Have you had a blood clot from pregnancy?	Yes	No				

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6. Are you taking birth control pills?	Yes	No	**If no, have you taken them in the past?**	Yes	No	
7. 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:					
2. Are you retired?	Yes	No			
3. 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	
4. Do you smoke?	Yes	No	**If yes, do you smoke: (circle)**	less than 9 cig/day	Greater than 10 cig/day

5. Do you use chewing tobacco?	Yes	No			
6. If you smoke:	**What age did you start? age______**	**How many packs per day? ____packs/day**	**Have you thought about quitting?**	Yes	No
7. 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**		
8. Marital Status?	Married	Unmarried	Divorced	Widowed	Other________
9. 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:____

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