Cosmetic Plastic Surgery Center

New Patient Form

Name:_____ Today's Date:_____/_____/_____

DOB:_____/_____/_____ Age:_____

Address: _____

City:_____ State: _____ Zip Code: _____

Home Phone: (_____)_____-_____ Cell Phone: (_____)_____-_____

Email:_____

Contact Preference (please circle): Home Phone / Cell Phone / Text / Email / Mail

Emergency Contact/Relationship:_____

Emergency Contact Phone: (_____)_____-_____

Occupation: _____ Employer:_____

How did you hear about us?_____

Medical History

Do you have any medical conditions? Y / N

If so, please explain: _____

_____

_____

Do you have a muscle or nerve condition (ex: ALS or Lou Gehrig's disease, Multiple Sclerosis, myasthenia gravis, Lambert-Eaton Syndrome)? Y / N

Do you have an Autoimmune Disease (ex: Rheumatoid Arthritis, Lupus, Crohn's)? Y / N

Do you have any Allergies or Hypersensitivity to medications? If so, please list:

_____

Do you have a Latex Allergy? Y / N Do you have a Lidocaine Allergy? Y / N

Are you taking an anti-inflammatory / blood thinning medication / supplements, such as Aspirin, Advil, Ibuprofen, Motrin, Aleve, Coumadin, Plavix, Fish Oil, Vitamin E, St John's Wort, Ginkgo Biloba, Flax Oil, Cod Live Oil, or Niacin? Y / N

If so, how often (please circle)? Daily / As needed / As prescribed by my Physician

Do you Bruise easily? Y / N Do you scar or keloid? Y / N Do you or have you taken Accutane Y /N When?

Please list any medications you are taking, including prescription, nonprescription medications, and supplements:

_____

_____

_____

Are you pregnant or trying to become pregnant? Y / N Are you Nursing? Y / N

Have you previously had Plastic Surgery to your Face/ Neck/ Chin? Y / N

If so, what surgery, and when? _____

Are you prone to cold sores? Y / N If yes, do you have an active cold sore at this time? Y / N

Aesthetic Injectable Questionnaire

Name:_____ Today's Date:_____/_____/_____

Interests/Concerns:

- ☐ **Botox** – Fine lines & Wrinkles around & between the Eye Forehead, Gummy Smile, Neck Lines, Bunny Lines, Lip Lines.
- ☐ **Dermal Fillers** – Loss of Volume in Mid to Lower Face (Cheeks, Nasolabial Folds, Marionette Lines, Lips).
- ☐ **Kybella** – Submental Fullness or "Double Chin."

What bothers you most?

_____

_____

_____

Have you previously had **Botox** injections? Y / N

When was your last treatment:_____

What areas were treated:_____

Were you happy with your results?_____

Have you previously had **Dermal Filler** Injections? Y / N

When was your last treatment:_____

What areas were treated:_____

What type of filler was used (ex: Juvederm, Voluma, Volbella, Restylane)

_____

Were you happy with your results?_____

_____

Are you a Brilliant Distinctions Member? Y / N Member #_____

Are you an Aspire Member ? Y /N Member #_____

Skin Questionnaire

Name:_____ Today's Date:_____/_____/_____

Describe your skin (please circle):

Dry to Normal Normal Normal to Oily Oily

List your primary concerns with your skin (Please circle):

Wrinkles Dark spots Redness Acne Dryness Texture Large Pores

Other: _____

What have you done in the past to address your concerns (ie: skin care products, laser treatments, facials, peels etc)?:

_____

_____

Did this improve your skin? YES NO

What are you currently using on your skin?

_____

_____

Has this improved your skin? YES NO

How many skin care products do you use a day? _____

Describe your AM routine (ie: " I wash my face with Obagi cleanser…):

_____

_____

_____

Describe your PM routine:

_____

_____

_____

Describe your lifestyle (ie: I spend a lot of time in the sun…)

_____

_____