



**FACIAL PLASTIC AND RECONSTRUCTIVE SURGERY
AESTHETIC NEW PATIENT HISTORY FORM
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JAMIE PAGE, LICENSED AESTHETICIAN**

Name: _____

Date of birth: ____/____/____ Last Age: _____ Height: _____ First Weight: _____ MI

Email: _____

May we use your email to contact you about special promotions: Yes No

Referral Information			
<input type="checkbox"/> Patient, Name: _____	<input type="checkbox"/> Friend, Name: _____	<input type="checkbox"/> Newspaper	<input type="checkbox"/> Magazine
<input type="checkbox"/> Physician/Dentist: _____	<input type="checkbox"/> Nurse, Name: _____	<input type="checkbox"/> Radio	<input type="checkbox"/> Website
<input type="checkbox"/> Other: _____		<input type="checkbox"/> Yellow Pages	

Please check service you are interested in:

- | | |
|---|--|
| <ul style="list-style-type: none"> <input type="radio"/> Basic Skin Care (Facial) <input type="radio"/> Specialized Facial _____ <input type="radio"/> Microdermabrasion <input type="radio"/> Hair Removal <input type="radio"/> Removal of Brown Spots, Red Spots <input type="radio"/> Rosacea Treatment | <ul style="list-style-type: none"> <input type="radio"/> Acne Treatment Program <input type="radio"/> Photorejuvenation <input type="radio"/> Waxing <input type="radio"/> Chemical Peels <input type="radio"/> Botox/Fillers |
|---|--|

SURGICAL PROCEDURES: *(Note: additional questionnaire to be completed)*

Have you had any SURGERIES? List the procedures and dates received if you can:

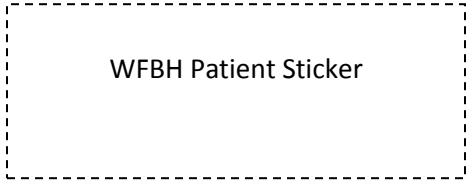
_____	When? _____
_____	When? _____
_____	When? _____
_____	When? _____

MEDICATIONS:

Are you taking any MEDICATIONS or DRUGS? If so, list below:

_____	How often? _____	What For? _____
_____	How often? _____	What For? _____
_____	How often? _____	What For? _____
_____	How often? _____	What For? _____

- Yes No Currently taking Accutane treatment? Last time taken _____
- Yes No Vitamins? _____
- Yes No Herbal Supplements? _____
- Yes No Have you taken any products containing Aspirin or blood thinners in the last 7 days?
- Yes No Are you allergic to any medications? Please list: _____
- Yes No Microdermabrasion?
- Yes No Collagen injections? If so, when? _____
- Yes No Recent facial surgery? If so, when? _____
- Yes No Laser resurfacing?
- Yes No Dermabrasion?
- Yes No Previous chemical peel - if so, what type? _____ When? _____



- Yes No Do alcohol products irritate your skin?
- Yes No Are you on antibiotics at this time? If so, what? _____
- Yes No Do you use glycolic or alphahydroxy skin care products?
- Yes No Have any skin care or makeup products caused any skin problems?
If so, explain _____
- Yes No Do you wear sunblock daily?
- Yes No Are you pregnant, nursing or planning a pregnancy?

Please list all products you are using on your skin including soaps, prescription topicals, creams, scrubs, etc.

What brand of makeup? _____

Your skin type is? (please circle one) Normal Dry/Dehydrated Oily Acne/Acne Prone Rosacea

When were you last exposed to sun or a tanning bed? _____

Have you or are you currently using Retin A? Yes No

If yes, what strength of Retin A have you used? (circle one) .025% .05% .1%

How long have you been using Retin A? _____

Are you undergoing any facial waxing procedures? Yes No If yes, what areas? _____

Have you experienced any of the following?

- | | | | | | |
|---|-----|----|---------------------------------------|-----|----|
| High or Low Blood Pressure | Yes | No | Depression / Severe mood swings | Yes | No |
| Seizures or Convulsions | Yes | No | Diabetes | Yes | No |
| Stroke | Yes | No | Fainting or dizzy spells | Yes | No |
| Asthma | Yes | No | Blood transfusion | Yes | No |
| Pulmonary embolus | Yes | No | Thrombophlebitis | Yes | No |
| Septicemia | Yes | No | Deep vein thrombosis | Yes | No |
| Hepatitis | Yes | No | Autoimmune disease (lupus, MS) | Yes | No |
| Easily bruise | Yes | No | Hemophilia/bleeding disease | Yes | No |
| Migraine headaches | Yes | No | Heart disease | Yes | No |
| Dark spots after pregnancy or injury .. | Yes | No | Immunodeficiency condition | Yes | No |
| Cancer | Yes | No | Rheumatoid arthritis | Yes | No |
| Scleroderma | Yes | No | Skin cancer | Yes | No |
| Keloid scars | Yes | No | Cold sores/herpes simplex | Yes | No |
| Treatment with Coumadin or Heparin | Yes | No | Abnormal response to light | Yes | No |
| Hormone replacement therapy | Yes | No | Treatment with Accutane | Yes | No |
| Circulatory problems | Yes | No | Abnormal heart condition | Yes | No |
| Tumors or cysts | Yes | No | Epilepsy | Yes | No |
| Cataracts / dry eye | Yes | No | Chemotherapy or radiation | Yes | No |
| Eye or eyelid surgery | Yes | No | Corneal abrasions | Yes | No |
| Visual disturbances | Yes | No | Contacts | Yes | No |
| | | | Other _____ | | |

Patient's Signature _____ Date/Time _____

Aesthetician's Signature _____ Date/Time _____

Reviewed by _____ Date/Time _____