Look Younger MD 2019 Patient Medical History

Patient Name (Print):______________________________________ ____Date:___ _________

Please complete so we may better serve you: Emergency Contact: ______________________

Do you smoke? Circle one: Yes, _____packs/day No; Regular Exercise? No Yes

Fitzpatrick Skin Type (circle one):

1. I - Always burns, never tans
2. II - Always burns, sometimes tans
3. III - Sometimes burns, always tans
4. IV - Rarely burns, always tans
5. V - Brown, moderately pigmented skin
6. VI - Black skin

HISTORY OF COSMETIC PROCEDURES

Have you ever had any facial surgery performed?

NO YES TYPE:____

Have you ever had any of the following injectable procedures done? Date: _________________

Circle: Botox Juvederm Restylane Radiesse Sculptra Other

Have you ever had any type of Chemical Peel?

NO YES TYPE: ____

Have you ever had any type of laser treatment?

NO YES TYPE: ____

Have you had any recent tanning or sun exposure that changed the color of your skin?

NO YES

Have you recently used any self-tanning lotions or treatments?

NO YES TYPE: ____

MEDICAL HISTORY: **Are you being treated by a physician (except for annual exams?)**

NO YES If YES, for what: ____

Are you currently under the care of a Dermatologist or Plastic Surgeon?

NO YES If YES, who and for what: ____

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Do you have any of the following medical conditions? (Please check all that apply)

☐ Cancer ☐ Diabetes ☐ Blood Pressure ☐ Herpes ☐ Arthritis ☐ Cold Sores
☐ HIV ☐ Skin Cancer ☐ Skin lesions ☐ Seizure ☐ Hepatitis ☐ Hormones
☐ Active Infections ☐ Acne ☐ Rosacea ☐ Thyroid ☐ Blood Disorders
☐ Anxiety ☐ Depression ☐ Body Dysmorphic Syndrome ☐ Fainting/Syncope

Any other health problems? If YES, PLEASE LIST: ____________________________

____

MEDICATIONS & ALLERGIES:

Do you have allergies to Latex, Epinephrine, Lidocaine, steroids, or ANY medications?

NO YES If YES, Please list ALL & TYPE of reaction you experience:

____

Please list ALL the medications (including OTC) you are currently taking:

____

____

Are you using Aspirin, Motrin Advil, Aleve), Coumadin, or Lovenox? NO YES

Do you have any of the following specific allergies? Please circle:

- Lidocaine/ Novocaine? YES Not to my Knowledge
- Hydroquinone or skin bleaching agents? YES Not to my Knowledge
- Hypersensitivity to Latisse®? YES Not to my Knowledge
- Any Botulinum toxin (Botox®) product? YES Not to my Knowledge
- Gram-positive bacterial proteins? YES Not to my Knowledge
- Do you have Errythema Abigne?
  (skin rash from heat or infrared irritation) YES Not to my Knowledge
- Food allergies? YES Not to my Knowledge
- If you circled "**YES**" to any of the above, please explain here: ____________________
  ____
  ____

Do you presently have or have you had a history of any of the following conditions?

- Any disease that affects muscles and nerves? NO YES
- Amyotrophic lateral sclerosis [ALS or Lou Gehrig's disease]? NO YES
- Myasthenia gravis or Lambert-Eaton syndrome? NO YES

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- Bleeding problems? NO YES
- Weakness of your forehead muscles, trouble raising your eyebrows? NO YES
- Drooping eyelids? (other than natural aging) NO YES
- Any other recent change in the way your face normally looks? NO YES
- Side effects from any Botulinum toxin product in the past? NO YES
- Breathing problems, such as asthma or emphysema? NO YES
- Swallowing problems? NO YES
- Do you form thick or raised scars (keloids) from cuts or burns? NO YES
- Hyperpigmentation (darkening of the skin) NO
  YES
- Hypopigmentation (lightening of the skin) NO
  YES
- Areas of persistent redness? NO YES
- Are you on immunosuppressive therapy? NO YES
- Do you have history of any eye pressure problems? NO YES
- Are you using IOP (intraocular pressure) medication? NO YES
- Intraocular Inflammation or Macular Edema? NO YES
- Have a pacemaker or internal defibrillator? NO YES
- Herpes, bacterial or fungal infections? NO YES
- Have any autoimmune disorders? NO YES
- Have had extensive radiation therapy? NO YES
- History of epilepsy? NO YES
- Scleroderma or other connective tissue disease? NO YES
- Are you using medications that make you sensitive to light? NO YES
- Do you have a history of anaphylaxis? NO YES
- Do you have multiple severe allergies? NO YES
- Are you using contraception? NO YES
- Pregnant or plan to become pregnant? NO YES
- Breast-feeding or plan to breastfeed? NO YES

If you circled "**YES**" to any of the above, please explain here:

I certify that the preceding medical, personal and skin history statements are true and correct. I am aware that it is my responsibility to inform the physician of my current medical or health conditions and to update this history. A

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current medical history is essential for the physician to execute appropriate treatment procedures.

Patient Name **(Please Print)**

Patient Signature Date

Reviewed with Patient Date

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