
# 2022 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

How many prior cosmetic wrinkle physicians, nurses, and PAs have given you treatments? ____

Have you had any of the following injectable procedures done? Last Treated: _____

Circle: Botox Juvederm Restylane Radiesse Sculptra Other _____

Have you ever had any Facial Surgery performed?

NO YES TYPE:_____

Have you ever had any type of Chemical Peel, Microneedling, PRP, or Laser Treatment?

NO YES TYPE: _____

Have you had any recent tanning or sun exposure or self-tanning lotions or treatments?

NO YES

**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 any medications or to Latex?**

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 skin rash from heat? 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?

- Forehead muscle weakness or trouble raising your eyebrows? NO YES
- Drooping eyelids? (other than natural aging) NO YES
- 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
- 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 or seizures? 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 agree that it is solely my responsibility to inform Dr. Lee of my current condition and to update this history at every visit if there are any changes to make sure my treatment is appropriate. I also agree that if Dr. Lee does not believe he can meet my expectations, I will accept referral elsewhere--even if onsite--to see a specialist for the very best results.

_____

Patient Name **(Please Print)**

_____

Patient Signature Date

_____

Reviewed with Patient Date



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