

PLEASE FILL IN BUBBLES COMPLETELY:

Family History

Please indicate if any of your siblings, parents or children have had the following:

- Basal Cell Skin Cancer Squamous Cell Skin Cancer Melanoma
 Non-skin Cancer Eczema Asthma Hay Fever
 Thyroid Disease Autoimmune Disease (e.g. Lupus or Rheumatoid Arthritis)
 None of the above

Surgical History

Please indicate if you have had any of the following procedures:

- Skin Cancer Surgery Mohs Surgery
 Botox Chemical Peel Acne Scar Treatment Hair Transplant
 Sclerotherapy (vein injections) Filler (e.g. Restylane, Juvederm, Radiesse) FAMI
 Facelift Blepharoplasty Liposuction Laser Surgery
 None of the above

Review of Systems

- Do you have trouble with wound healing? Yes No
Do you tend to bleed excessively? Yes No
Do you have a tendency to form hypertrophic scars and keloids? Yes No
Have you had allergic reactions to bandages and tape? Yes No
Do you have enlarged lymph nodes? Yes No
Are you immunosuppressed e.g. have HIV/AIDS or history of lymphoma or leukemia? Yes No
Do you have a prosthetic hip or knee joint? Yes No
Do you have a pacemaker/defibrillator? Yes No
Do you take aspirin or coumadin or other anticoagulants? Yes No
Do you have mitral valve prolapse? Yes No
Do you have a history of blood clots or emboli? Yes No
Have you ever fainted or become light-headed with minor surgical procedures? Yes No

Would you like information on (please circle):

- | | |
|--|--|
| <input type="checkbox"/> Botox treatments | <input type="checkbox"/> Fillers (Restylane, Juvederm, Radiesse, Collagen) |
| <input type="checkbox"/> Laser Hair Removal | <input type="checkbox"/> Sclerotherapy for Varicose and Spider Veins |
| <input type="checkbox"/> Laser Treatment for Spider Veins | <input type="checkbox"/> Chemical Peels (e.g. Jessner's, Glycolic Acid, TCA) |
| <input type="checkbox"/> IPL (Fotofacial) | <input type="checkbox"/> Scar Treatments (e.g. acne scars) |
| <input type="checkbox"/> Laser Acne Peels | <input type="checkbox"/> Removal of Age Spots, Sun Spots, Moles, Skin Tags |
| <input type="checkbox"/> Latisse (for Eyelash Lengthening) | <input type="checkbox"/> Colorescience Mineral Makeup and Sunblock |

Signature: _____

Date: _____