HEALTH QUESTIONNAIRE

Thank you exploring your aesthetic options with us. To provide you with the safest and most appropriate care, we will need the following information. This information is kept in your *confidential* file.

	Date of Birth:	Age:
Full Name:	Weight:	Height:
Spouse / Partner's Name:	# of Pregnancies:	# of Live Births:

Do you currently have, or have you ever been treated for any of the following? *(Mark NONE if none apply):*

☐ NONE	☐ Cholesterol	☐ Hepatitis A	☐ Numbness	☐ Thyroid
☐ Acid Reflux	☐ Cold sores	☐ Hepatitis B	☐ Pneumonia	☐ Tuberculosis
☐ Anemia	☐ Diabetes	☐ High blood pressure	☐ Productive cough	☐ UTI's
☐ Aneurysm	☐ Emphysema	☐ High blood sugar	☐ Seizures	☐ Weakness
☐ Asthma	☐ Eye problems	☐ HIV / AIDS	☐ Sickle cell	☐ Other:
☐ Blood Clots	☐ Heart attack	☐ Irregular heartbeat	☐ Sleep Apnea	________
☐ Chest pain	☐ Heart Disease	☐ Kidney problems	☐ Stroke	________

Do you have an allergy to Latex? ☐ YES ☐ NO

Do you bruise easily? ☐ YES ☐ NO

Any abnormal bleeding? ☐ YES ☐ NO

Do you exercise? ☐ YES ☐ NO

How many times per week? ____________

Have you had a Mammogram in the last… ☐ 6 months ☐ 1 yr ☐ 5 yrs ☐ Never ☐ N/A

How would you describe your results? ☐ Abnormal ☐ Normal

How often do you take NSAIDS ☐ Daily ☐ Weekly ☐ Rarely ☐ Never ☐ Allergic
(Advil, Aleve, Ibuprofen, Aspirin, etc.)

Do you use Nicotine products? ☐ Cigarettes ☐ Chew ☐ Vape ☐ e-Cigarette ☐ Nicotine Gum
☐ Tobacco ☐ Patch ☐ None

If yes, how many times per week? ________ *If cigarettes, how many packs per week?* ____________

Have you recently used any recreational drugs? ☐ YES ☐ NO *If yes, what?* ____________

Do you drink alcohol? ☐ YES ☐ NO *If yes, how many times per week?* ____________

Please list all minor and major operations and dates. This includes any form of cosmetic procedure ***(Write NONE if none)***:

Type of Surgery:	Date:	Type of Surgery:	Date:

Please list any anesthesia complications, if any ***(write NONE if none):***

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Please list ALL your food and drug allergies ***(Write NONE if none)***:

Allergy to:	Reaction:	Allergy to:	Reaction:

Please list all medications, including over the counter drugs, supplements and herbal additives. ***(Write NONE if none)***:

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Family History:	Yes	No	Afflicted Family Member	Notes / Other Family Members
Adopted				
Abnormal Bleeding				
Abnormal Clotting				
Anesthesia Problems				
Aneurysm				
Autoimmune Disorders				
Breast Cancer				
Cancer				
Diabetes				
Endocrine Disease				
Heart Disease				
Hemophilia				
High Blood Pressure				
Liver Disease				
Lung Disease				
Malignant Hyperthermia				
Pulmonary Embolism				
Skin Cancer				
Skin Disease				
Substance Abuse				
Von Willebrand				

What are some of your appearance concerns? / I am interested in learning about:

- ☐ Aging eyes
- ☐ Aging face
- ☐ Neck
- ☐ Thin lips
- ☐ Wrinkles
- ☐ Laxity of skin
- ☐ Cellulite
- ☐ Skin quality
- ☐ Gluteal shape
- ☐ Breast size
- ☐ Nasal appearance
- ☐ Body contour
- ☐ Abdominal shape
- ☐ Leg contour
- ☐ Breast shape
- ☐ Gluteal size
- ☐ Skin resurfacing
- ☐ Breast implants
- ☐ Breast lifting
- ☐ Facial filler
- ☐ Botox
- ☐ Eyelid surgery
- ☐ Facelift
- ☐ Neck lift
- ☐ Nasal surgery
- ☐ Tummy tuck
- ☐ Liposuction
- ☐ Post weight loss surgery
- ☐ Skin resurfacing
- ☐ Skin tightening