MAINE

PLASTIC SURGERY CENTER

CLIENT INFORMATION & MEDICAL HISTORY

PERSONAL HISTORY

Client Name_____ Today's Date _____

Date of Birth_____Age _____ Occupation_____Phone Number:_____

Home Address_____City_____ State_____Zip_____

Emergency Contact Name _____Relation: _____Phone Number_____

How were you referred to us? _____ Email: _____

SKIN HISTORY

What concerns you? (Please check all that apply)

☐ Fine Lines & Wrinkles ☐ Enlarged Pores ☐ Sun Damage ☐ Discoloration

☐ Rosacea ☐ Loss of Facial Volume/Contours ☐ Uneven Texture ☐ Skin Disease

☐ Acne/Oily/Breakouts ☐ Dry, Flaky Skin ☐ Lax or Sagging Skin ☐ Scarring

☐ Double Chin ☐ Dark Under-Eye Circles ☐ Dilated Capillaries/Redness

Please list your skin care regimen at home:

Cleanser_____ Toner_____Serum_____

Moisturizer_____ SPF_____

Any other home care products: _____

Are you prone to cold sores or fever blisters? ☐ Yes ☐ No

If yes, when was last occurrence? _____

Do you have any other health problems or medical conditions? Please List

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List any allergies or reactions:

☐Food ☐Animal Protein ☐Aspirin ☐Lidocaine ☐Hydrocortisone ☐ Hydroquinone

☐Skin Bleaching Agents ☐Other: _____

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MEDICATIONS

What oral prescription medications are you presently taking? ☐Birth control pills ☐Hormones ☐Others

(It is required that you list all of them): _____

Do you take any medications for heart conditions? _____

What topical medications or creams are you currently using? ☐Retin A ☐Others (Please list):

_____

What herbal supplements do you use regularly? _____

Are you currently taking any blood thinners? ☐Yes ☐No

Do you have any autoimmune disorders? ☐Yes ☐No

(Please list) _____

Are you prone to keloid scarring? ☐Yes ☐No

Do you have a history of skin cancers? ☐Yes ☐No

Do you sunbathe or spend a lot of time in the sun? ☐Yes ☐No

Have you taken Accutane in the past? ☐Yes ☐No

If yes, when was last dosage use? _____

Is there anything else that should be known before your consultation or treatment?

For our female clients:

Are you pregnant or trying to become pregnant? ☐Yes ☐No Are you breastfeeding? ☐Yes ☐No

Are you using contraception? ☐Yes ☐No

I certify that the preceding medical, medication and personal history statements are true and correct. I am aware that it is my responsibility to inform the doctor or other health professional of my current medical or health conditions and to update this history. A current medical history is essential for the caregiver to execute appropriate treatment procedures.

Signature_____ Date:_____

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AMERICAN SOCIETY OF PLASTIC SURGEONS

I, _____, permit my surgeon, treatment provider or his/her designee to take photos and/or videos before, during, and after my procedure. These may be of me or parts of my body. I agree that my provider can share them with staff, other health professionals, and the public. This may be done for educational or marketing purposes.

I understand that once my images are published, I lose control over their use. I have no control over where they are published. I agree to give up certain rights to my image. I release any claim I may have to the publication of such images. This includes any payment for their distribution.

I understand that images posted online may be saved. They may be available forever. They may be found in online searches. I realize that people may repost my images without my provider's consent. This may be used in social media. Neither I nor my provider have any control over this. I agree that my provider is not responsible for third-party use. I release my provider from any claim that might arise from this use.

I agree that my provider can use my images in the following context:

Please initial <u>ONLY ONE</u> of the following:

____ALL MEDIA: My images and medical details may be used in print and broadcast media. This includes newspapers, pamphlets, educational films, the internet (including social media and applications), and television.

____WEBSITE ONLY: My images and medical details may be used on my provider's website.

____ ALBUM ONLY: My images and medical details may be used in printed and/or digital photograph albums. The albums will only be used to show other patients my provider's methods.

I agree to the educational use of my images. I have fully read and understand the above terms. I have made my decision carefully and understand the risks.

PATIENT SIGNATURE: _____ Date: _____

Printed Name: _____

WITNESS SIGNATURE: _____ Date: _____

Printed Name: _____

For patients under the age of 18:

I, the parent or guardian of _____, a minor, am authorized to sign this release on his or her behalf. I agree to the educational use of his or her images.

PARENT/GUARDIAN SIGNATURE: _____ Date: _____

Printed Name: _____

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