Landon
PLASTIC SURGERY

Client Medical History

Today's Date: _____

Name: _____ **Age:** _____

Date of Birth: _____ **Occupation:** _____

ALLERGIES:

YES **NO** Do you have a **LATEX allergy?**

YES **NO** Do you have any allergies to ANY medications?

If yes, please specify what medications and the reaction that you have to them below:

_____

_____

_____

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

- ❑ NONE
- ❑ Cancer
- ❑ Diabetes
- ❑ High Blood Pressure
- ❑ Herpes/Cold Sores
- ❑ Seizure Disorder
- ❑ Hepatitis
- ❑ Hormone Imbalance
- ❑ Rosacea
- ❑ Active Infection
- ❑ Thyroid Imbalance
- ❑ Bleeding disorder
- ❑ Arthritis
- ❑ HIV/AIDS
- ❑ Skin Disease
- ❑ Autoimmune disorder
- ❑ Immunosuppressive therapy
- ❑ Scleroderma/ connective tissue disease
- ❑ Any disease that affects muscles and nerves

Do you have any other health problems or conditions other than those listed? Please specify.

_____

_____

_____

Please circle YES or NO as it applies to you:

YES **NO** Do you smoke?

If yes, how many times per day:_____

YES **NO** Do you consume alcohol?

Women Only:

YES **NO** Are you currently pregnant or plan to become pregnant?

YES **NO** Are you currently breast-feeding?

MEDICATIONS: Are you currently taking:

- ❑ Aspirin
- ❑ NSAIDs (Motrin, Advil, Aleve)
- ❑ Blood thinners
- ❑ Accutane
- ❑ Fish Oils
- ❑ Antibiotics
- ❑ Thyroid Medication
- ❑ Cortisone or steroids
- ❑ Hormones/contraceptives
- ❑ Antidepressants

Please list ALL medications and/or supplements that you are currently taking <u>other than</u> those specified above:

_____

_____

_____

<u>Procedures/Products of interest to you:</u>

- ❑ Botox, Dysport, or Xeomin
- ❑ Dermal Fillers (Juvederm, Restylane, Sculptra, etc.)
- ❑ Skin Care Advice/products
- ❑ Microneedling
- ❑ Platelet Rich Plasma for skin and/or hair rejuvenation
- ❑ Resurfacing Laser/ Laser skin rejuvenation
- ❑ Rosacea treatment (redness)
- ❑ Hyperpigmentation (brown spots)
- ❑ Leg Vein Removal
- ❑ Chemical Peels
- ❑ Acne Treatment
- ❑ Other, please specify: _____

History of Cosmetic/Aesthetic Treatments: (please circle yes or no)

YES **NO** Have you ever had any facial surgery? (ie. face lift, brow lift, facial implants, etc.)

Type:_____

YES **NO** Have you ever had aesthetic laser treatments?

Type: _____

YES **NO** Have you ever had microneedling or chemical peels?

Type: _____

YES **NO** Have you had any recent tanning, sun exposure that has changed the color of your skin?

YES **NO** Have you recently used any sunless tanner?

Have you ever had any of the following injectable treatments? Circle all that apply below.:

BOTOX Dysport Xeomin Juvederm Restylane Volbella Vollure

Voluma Radiesse Sculptra Versa BellaFill Silicone Fat

OTHER: _____

If you have had any of the treatments above, have you ever had any issues or problems with any of them? If yes, please list below:

_____

_____

_____

What is your current skincare routine?

_____

_____

_____

_____

I have answered the questions in this questionnaire to the best of my knowledge. I understand it is my responsibility to inform my healthcare provider of my current health conditions while seeking treatment as a patient. I will update this information as it occurs if there are changes in my health in between treatments.

_____ _____

Patient Signature **Date**