

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 a history of immunosuppression, lymphoma or leukemia? Yes No

Do you have a history of or exposure to HIV, hepatitis B or C? 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):

- | | |
|-------------------------------------|---|
| Botox treatments | Fillers |
| IPL (Fotofacial) | Microneedling for acne scars, wrinkles, skin rejuvenation |
| Laser Resurfacing | PRP Injections for Hair Loss |
| Chemical Peels | Laser Hair Removal |
| Leg Vein Treatment | Kybella for chin/neck fullness |
| Skincare Products (e.g. anti-aging) | Latisse (for Eyelash Lengthening) |

Signature: _____

Date: _____