New You Center for Advanced Medical Aesthetics

Name_____

Address_____

City_____State_____Zip _____

Phone_____ Home Cell Work

Phone_____ Home Cell Work

Birthdate_____ Age _____ Referred By_____

What type of problem are you consulting for?

□ Age spots/sun damage □ Wrinkles □ Acne □ Scarring
□ Enlarged blood vessels □ Sagging skin □ Hair □ Skin color/texture
□ Large pores □ Fat/Cellulite □ Moles □ Other _____

How many years have you noticed this problem? _____
If skin related, at what age did your problem begin? _____

Have you ever been treated for this problem? □ Yes □ No
If yes, when? _____
By what method? _____

List any past surgeries _____
_____

List any prior hospitalizations _____
_____

Do you have a personal history of any of the following?

□ Heart problems □ Pacemaker □ Bowel disease □ Mitral valve prolapse
□ Diabetes □ Heart murmur □ HIV/Aids □ High blood pressure
□ Herpes □ Glaucoma □ Artificial joints □ Kidney problems
□ Cancer □ Blood clots □ Bleeding disorders □ Easy bruising
□ Arthritis □ Seizures □ Muscle weakness □ Dark spots post pregnancy
□ Skin injury □ Hepatitis □ Thyroid disease □ Skin cancer/suspicious moles

Do you have a family history of any of the following?

□ Skin cancer/melanoma □ Abnormal moles □ Bleeding problems

Do you take any medication?

□ Aspirin □ Blood thinners □ Anti-depressants/anxiety medications
□ Insulin □ Anti-inflammatories □ Hormones/contraceptives
□ Diet pills □ Thyroid medication □ Other _____
□ Sedatives □ Cortisone

Do you have any allergies to medication? □ Yes □ No
If yes, please specify_____

Do you have any skin related allergies? □ Yes □ No If yes, specify _____
Are you allergic to latex? □ Yes □ No Betadine? □ Yes □ No

Do you take antibiotics before dental work? □ Yes □ No Why?_____

Are you taking any over-the-counter medicines or herbal preparations? (i.e. ibuprofen, fish oil, vitamins)? □ Yes □ No Please list _____

Have you had any allergic reactions to anesthesia? □ Yes □ No
If yes, please specify_____

Do you smoke? □ Yes □ No
Do you drink alcohol? □ Yes □ No How often? _____

Are you pregnant, nursing, or planning a pregnancy soon? □ Yes □ No

Have you had cold sores or fever blisters? □ Yes □ No
Do you have a history of keloid scarring? □ Yes □ No

Mark your skin type (when exposed to the sun for about one hour with no protection):

I	Always burns, never tans	□
II	Always burns, sometimes tans	□
III	Sometimes burns, sometimes tans	□
IV	Always tans	□
V	Asian, Hispanic, Mediterranean, Middle Eastern	□
VI	Black	□

When were you last exposed to the sun (or tanning booth)? _____

Do you use self-tanners or spray tans? □ Yes □ No

Are you planning a vacation in the sun? □ Yes □ No

Have you ever had skin resurfacing or rejuvenation or chemical peels? □ Yes □ No

Have you ever had treatments for pigmented lesions? □ Yes □ No
Prior treatment (if any) _____

Patient Signature _____ Date _____