Aesthetic
Medical Center

D. Dennis Faludi, M.D.

Patient Medical History Form

Do you have or have you ever had any of the following? Please check all that apply:

____ Allergies
____ Anxiety Disorder
____ Arthritis/Joint Problems
____ Autoimmune Disorder
____ Back Problems
____ Blood Disease
____ Cancer
____ Chemical Dependency
____ Circulatory Problems
____ Depression
____ Diabetes
____ Epilepsy
____ Headaches
____ Heart Problems
____ Hemophilia/Bleeding Disorder
____ Hepatitis/Liver Disease
____ High Blood Pressure
____ HIV/AIDS
____ Joint Prosthesis
____ Mitral Valve Prolapse
____ Pacemaker
____ Prostate Problems
____ Psychiatric Care
____ Radiation Treatment
____ Recent Weight Loss
____ Respiratory Disease
____ Sinus Problems
____ Stroke
____ Swollen Neck Glands
____ Thyroid Problems
____ Ulcer Disease
____ Venereal Disease

Please list previous surgeries and aesthetic procedures, including dates: _____

_____

Please list all medications you are currently taking (including aspirin and any NSAIDS):

_____

_____

Please list all vitamins and nutritional supplements you are currently taking: _____

_____

Allergies: _____

Have you ever had a reaction to any of the following? Please check all that apply:

_____ Iodine
_____ Seafood
_____ Collagen injections
_____ Porcine (pig) products
_____ Hyaluronic acid injections
_____ Any dermal fillers
_____ Any local anesthetic, including lidocaine
_____ Eggs/albumin

Do you regularly sunbathe, use tanning booths, or apply tanning creams? YES NO

If yes, when was the last time you did any of the above? _____

Have you ever had dermabrasion or a chemical peel? YES NO

If yes, what was the date of your last treatment? _____

Are you currently using, or have you ever used Retin-A? YES NO

If yes, when did you start? _____ When did you stop? _____

Are you currently using, or have you ever used Accutane? YES NO

If yes, when did you start? _____ When did you stop? _____

Do you have any skin conditions? YES NO

If yes, please specify: _____

Do you have, or have you ever had vitiligo (loss of skin pigment)? YES NO

If yes, how has it been treated? _____

Do you ever get cold sores, canker sores, or herpes eruptions? YES NO

If yes, how has the condition been treated? _____

Do you form keloids (extra large/prominent scars)? YES NO

Do you currently smoke? YES NO

If yes, how many packs per day? _____ How many years? _____

Do you drink alcohol? YES NO

Are you pregnant or planning to become pregnant? YES NO

Are you currently breastfeeding? YES NO

What is the main reason for your visit today? _____

_____

Please list all areas of concern that are relevant to you and numerically rank them in order of importance:

____ Fine lines and wrinkles

____ Lines around nose and mouth

____ Skin texture

____ Uneven skin tone

____ Dark circles or bags under eyes

____ Acne

____ Scars/acne scars

____ Brown/red/purple discolorations

____ Spider veins, face or legs

____ Hands (loss of volume, veins, discoloration)

____ Sun damage

____ Other _____

____ Other _____

____ Other _____

Are there any specific questions you would like to have answered during your initial visit?

_____

_____

LIMITATION OF TREATMENT

Please understand that our practice is strictly limited to cosmetic procedures. You understand and acknowledge that **we do not examine or treat you for malignancy** (cancer) or non-cosmetic skin abnormalities. Skin cancer is an extremely serious (potentially fatal) condition and must be treated **immediately**. You should be examined on a regular basis by a dermatologist, and you should bring any concerns regarding skin changes or skin cancer to the attention of a dermatologist immediately.

BY YOUR SIGNATURE BELOW, YOU ACKNOWLEDGE THAT YOU HAVE READ AND FULLY UNDERSTAND THE CONTENTS OF THE FOREGOING.

_____ _____ _____

Patient Signature **Print Name** **Date**