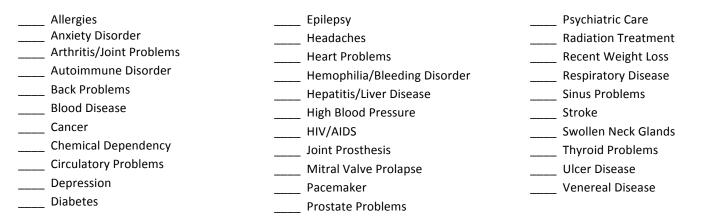


## D. Dennis Faludi, M.D.

## **Patient Medical History Form**

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



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	<ul> <li>Hyaluronic acid injections</li> <li>Any dermal fillers</li> <li>Any local anesthetic, including lidoca</li> <li>Eggs/albumin</li> </ul>	ine
Do you regularly sunbathe, use tanning booths, or apply tann	ing 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	
Have you been vaccinated against COVID-19?	When?			
What is the main reason for your visit today?				
Please list all areas of concern that are relevant to you and nu	merically rank them in order of importan	ce:		
Fine lines and wrinkles	Brown/red/purple discolo	rations		
Lines around nose and mouth	Spider veins, face or legs	_ Spider veins, face or legs		
Skin texture	Hands (loss of volume, vei	_ Hands (loss of volume, veins, discoloration)		
Uneven skin tone	Sun damage			
Dark circles or bags under eyes	Other			
Acne	Other			
Scars/acne scars	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.