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

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 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**