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**11409 Ash Street, Suite B**

**Leawood, KS 66211**

**Phone: 913-451-8346**

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| **Patient Information** |

Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age\_\_\_\_\_\_\_\_\_ Employer\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State\_\_\_\_\_\_\_\_ Zip\_\_\_\_\_\_\_\_\_

Cell # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Home #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Preferred method of contact\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Can leave a message at: Home \_\_\_\_\_\_\_ Work\_\_\_\_\_ Cell\_\_\_\_\_\_\_ Email\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact Name & Number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Pharmacy Name & Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Height\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Weight\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Occupation\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you drink Alcoholic beverages? Y / N If yes, how frequently\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you Smoke? Y / N If yes, how frequently \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­­\_\_\_\_\_\_\_\_\_

How much water do you drink daily?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you pregnant or trying to become so? Y / N

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| **Procedures or products of interest to you: (Check all that apply)** |

\_\_\_Acne Treatments \_\_\_Micro-Dermabrasion \_\_\_\_Hair Removal

\_\_\_Botox \_\_\_Xeomin \_\_\_\_Skin Photo-rejuvenation

\_\_\_Micro-Laser Peels \_\_\_ (dermal fillers) Radiesse, Juvederm, Restylane

\_\_\_CoolSculpting \_\_\_Venus Freeze \_\_\_Precision Lipo

\_\_\_Varicose Veins \_\_\_Spider Veins \_\_\_Laser Hair Removal

**Have you ever received any of the above treatment?**

**If so, please list.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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**What type of problem are you consulting for:**

Sun Spots

Wrinkles

Enlarged blood vessels

Flushing of the skin

Large pores

Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How many years have you noticed this problem?

At what age did your skin problem begin?

Are your present skin problems getting more pronounced?

Do you have a history of keloid scarring?

Please list all Medication Allergies including LATEX Allergies: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Do you have a history of:**

\_\_\_\_\_Heart disease \_\_\_\_ ­ Diabetes

\_\_\_\_\_Herpes sores \_\_\_\_Bleeding disorders

\_ \_\_\_\_Bruising \_\_\_\_Dark spots after pregnancy

\_\_\_\_\_Skin injury \_\_\_\_Skin cancer, or suspicious moles

Have you had any allergic reactions to anesthesia? Yes No

Do you have any skin related allergies? Yes No

If yes, please specify\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have any allergies to medication? Yes No

If yes, please specify\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Do you take any medication?**

\_\_\_\_ Aspirin \_\_\_\_ Anti-coagulants (blood thinners)

\_\_\_\_ Hormones/contraceptives \_\_\_\_ Appetite depressant (diet pills)

\_\_\_\_ Thyroid medication \_\_\_\_ Insulin

\_\_\_\_ Sedatives \_\_\_\_ Tranquilizers

\_\_\_\_ Cortisone Other (please specify)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you taking any herbal preparations: (St. John’s Wort) Yes No

If yes, please list\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you wear contact lenses? Yes No

Have you had cold sores or fever blisters? Yes No

How often do you tend to break out?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please list all surgeries that you have had (include plastic surgery and wisdom teeth removal) with the date you had the surgery:**

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| I acknowledge that I have disclosed my complete medical history and the above is a complete and accurate representation of my medical and psychological status. I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, represent to the physicians and staff that I am at least 18 years of age or, if not, am accompanied by a legal guardian. I hereby consent to and authorize a history examination by my doctor and such assistant or staff as may be assigned by him/her.  I understand that photography is a necessary part of planning and evaluating cosmetic procedures. I authorize the taking of photographs at the direction of my physician or physician delegate and under such conditions as may be approved by him/her. It is understood the use of photographs is for illustrating the medical procedure and demonstration of treatment outcomes. It is also understood that the use of the photographs will in no way reveal patient identity.  Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Witness:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |