



## Health History

Do you currently have any existing skin conditions, such as, scars, rash, acne, pigmentation, spider veins?

No  Yes If yes, please specify condition and duration: \_\_\_\_\_.

Are you or have you ever used Renova, Retin A, Retinoids, Tazarac, Avage, Alpha Hydroxy or Glycolic Acid?

No  Yes If yes, please specify duration and strength: \_\_\_\_\_.

Are you or have you ever used Accutane (generic: Sotret)?

No  Yes If yes, please specify duration and strength \_\_\_\_\_.

Are you currently or have you ever received radiation therapy?

No  Yes If yes, please specify area, duration and strength: \_\_\_\_\_.

Do you have any implants, tattoos, or permanent makeup in/on the area to be treated?

No  Yes If yes, please specify type and location:

\_\_\_\_\_.

Have you ever had an acid peel?

No  Yes If yes, please specify: \_\_\_\_\_.

How would you best describe your skin?

Oily  Oily to Normal  Normal  Normal to Dry  Dry

Please list the brand names for all that apply:

Cleanser \_\_\_\_\_ Toner \_\_\_\_\_ Moisturizer \_\_\_\_\_

Mask \_\_\_\_\_ Eye Cream \_\_\_\_\_ Sunscreen \_\_\_\_\_

Night Cream \_\_\_\_\_ Other \_\_\_\_\_

Has an endocrinologist ever treated you?

No  Yes If yes, please explain: \_\_\_\_\_

\_\_\_\_\_.

## Medications and Allergies

Medications	Allergies

## Conditions

Conditions: check all existing conditions.

- |  |                                     |  |  |  |
|--|-------------------------------------|--|--|--|
| <input type="checkbox"/> AIDS              | <input type="checkbox"/> Cancer     | <input type="checkbox"/> Guillian-Barre    | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Pacemaker       |
| <input type="checkbox"/> Asthma            | <input type="checkbox"/> Cold Sores | <input type="checkbox"/> Headache          | <input type="checkbox"/> HIV positive        | <input type="checkbox"/> Pregnancy       |
| <input type="checkbox"/> Bell's Palsy      | <input type="checkbox"/> Contacts   | <input type="checkbox"/> Heart Condition   | <input type="checkbox"/> Moles               | <input type="checkbox"/> Stroke          |
| <input type="checkbox"/> Bleeding Disorder | <input type="checkbox"/> Diabetes   | <input type="checkbox"/> Hepatitis         | <input type="checkbox"/> Multiple Sclerosis  | <input type="checkbox"/> Bruising Easily |
| <input type="checkbox"/> Epilepsy          | <input type="checkbox"/> Herpes     | <input type="checkbox"/> Myasthenia Gravis |  |  |

\_\_\_\_\_ I hereby state that all the facts or information, including pertinent facts concerning my past medical and surgical history that have been furnished to the treatment provider during my preoperative evaluation is complete and correct. The treatment provider has explained, in terms clear to me, the effect and nature of the procedure(s) to be performed, foreseeable risks involved and alternative treatment methods. I know that the practices' of medicine, cosmetics and laser are not exact sciences and that reputable professionals cannot guarantee results. I acknowledge that no guarantee or assurance has been made by anyone regarding the procedure(s), which I herein have requested and authorized. I have been advised that the goal of the procedure(s) that I have requested, have the possibility of imperfections which ensue and that the results may not live up to my expectations or to the goals that have been established.

\_\_\_\_\_ I certify that the above information is correct to the best of my knowledge and I will not hold Hall Plastic Surgery and Rejuvenation Center or their staff responsible for any errors or omissions that I have made on this form.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date

\_\_\_\_\_  
Physician

\_\_\_\_\_  
Date