LIFETIME HEALTH CENTER AESTHETIC INTEREST QUESTIONNAIRE

FIRST & LAST NAME:_____DATE:_____

DOB:_____ AGE:_____ GENDER:_____

HOME PHONE: _____ CELL PHONE: _____

PRIMARY CARE PHYSICIAN IF NOT LIFETIME HEALTH CENTER:_____

EMERGENCY CONACT:_____ PHONE#:_____

FEMALES:	ARE YOU PREGNANT?	YES	NO
	ARE YOU BREASTFEEDING?	YES	NO
	ARE YOU PLANNING PREGNANCY DURING THE COURSE OF TREATMENT?	YES	NO
	DO YOU HAVE REGULAR PERIODS?	YES	NO
	ARE YOU MENOPAUSAL?	YES	NO
	DO YOU HAVE A HORMONAL IMBALANCE?	YES	NO
	DO YOU TAKE A BIRTH CONTROL?	YES	NO
	HAVE YOU HAD A HYSTERECTOMY?	YES	NO

DATE:_____

COMPLETE THE FOLLOWING ITEMS OF YOUR MEDICAL HISTORY. ALWAYS INFORM US OF ANY CHANGES IN YOUR MEDICAL HISTORY AND/OR MEDICIATIONS.

LIST ALL MEDICATIONS INCLUDE PRESCRIPTION AND OVER THE COUNTER DRUGS, VITAMINS, HERBS, AND SUPPLEMENTS:

_____

_____

_____

PLEASE CIRCLE ONE:

ARE YOU USING ANY MEDICATIONS PURCHASED OUTSIDE OF THE USA? YES NO

ARE YOU ALLERGIC TO ANY MEDICATIONS? YES NO

PLEASE LIST MEDICATIONS YOU ARE ALLERGIC TO WITH REACTIONS:

_____

_____

PLEASE MARK X ON ALL THAT APPLY:

___ACNE	___HIGH BLOOD PRESSURE	___ROSACEA
___BLEEDING DISORDERS	___HIRSUTISM	___SHINGLES
___COSMETIC TREATMENTS	___HORMONE THERAPY	___BURNS/SKIN GRAFTS
___MOLES	___SKIN CANCER	___DIABETES
___TATTOOS	___ ANAPHYLAXIS	___HEPATITIS
___THYROID DISEASE	___CONNECTIVE TISSUE DISEASE	___LUPUS ERYTHEMATOSUS
___VITILIGO	___METAL PINS	___PERMANANT MAKEUP
___PACEMAKER/DEFIBRILLATOR	___DERMITISIS/ECZEMA	___HISTAMINE REACTIONS
___POLYCYSTIC OVARY DISEASE	___HEART DISEASE/CONDITION	___PORT-WINE STAIN
___ORAL/VAGINAL/NASAL HERPES		___ IMPLANTS TYPE:_____

(MUST START PREVENTITIVE RX PRIOR TO TX)

___PSORIASIS	___SPIDER VEIN/VASCULAR LESIONS	___HEARING AID

___ FILLER INJECTIONS (BOTOX, ETC) TYPE: _____ LAST INJECTION: _____

IF OTHER PLEASE LIST:_____

PLEASE ANSWER QUESTIONS BELOW AND CIRCLE ONE:

ARE YOU CURRENTLY BEING TREATED WITH ANTIBIOTICS? YES NO

HAVE YOU SEEN A PHYSICIAN REGARDING YOUR SKIN RECENTLY? YES NO

DO YOU HAVE ANY ACTIVE SKIN DISEASES OR INFECTION IN THE AREA TO BE TREATED? YES NO

DO YOU HAVE ANY SKIN ALLERGIES? YES NO

DO YOU HAVE ANY HISTORY OF SKIN CANCER OR PRECANCERSOUS LESIONS? YES NO

DO YOU HAVE PSORIASIS/ECZEMA IN THE AREA TO BE TREATED? YES NO

ARE THERE ANY MOLES WITH HAIR IN THE AREA TO TREAT? YES NO

ARE YOU ALLERGIC TO LATEX, LIDOCAINE, LOTIONS OR ALOE VERA? YES NO

EXPLAIN REACTION:_____

HAVE YOU EVER HAD SURGERY IN THE AREA TO BE TREATED? YES NO

HAVE YOU HAD ANY PREVIOUS LASER TREATMENTS, ELECTROLYSIS OR OTHER YES NO

SKIN TREATMENTS TO THE AREA YOU WILL BE TREATED AT TODAY?

DESCRIBE:_____ DATE:_____

ANY REACTION AFTER TREATMENT:_____

HAVE YOU/ARE YOU USING MEDICATIONS SUCH AS ACCUTANE IN THE LAST 6 MONTHS? YES NO

DATE OF LAST DOSE:_____

ARE YOU USING RETIN-A, RENOVA, DIFFERIN, OR TAZORAC? YES NO

ARE YOU USING GLYCOLIC/AHA HOME CARE PRODUCTS? YES NO

WHAT SKIN CARE PRODUCTS ARE YOU CURRENTLY USING?_____

DO YOU SMOKE? YES NO

DO YOU SUNBATHE? YES NO

DATE OF LAST SUN EXPOSURE:_____

ARE YOU CURRENTLY USING, OR HAVE YOU USED A TANNING BED OR SELF TANNER? YES NO

DATE OF LAST USE:_____

DO YOU USE SUNSCREEN? YES NO

WHAT SPF:_____ HOW OFTEN? OCCASIONALLY SUMMER ONLY

DO YOU USE FACIAL DEPLIATORIES OR CHEMICAL HAIR REMOVAL (NAIR)? YES NO

DOES YOUR SKIN REMAIN DISCOLORED AFTER HEALING FROM A CUT? YES NO

DO YOU HAVE ANY MUSCULAR DISORDERS? YES NO

PLEASE INDICATE WHICH OF THE FOLLOWING CONCERNS YOU HAVE ABOUT YOUR SKIN:

___AGED SKIN ___HYPERPIGMENTATION ___ONYCHOMYCOSIS (NAIL FUNGUS)

IF OTHER PLEASE EXPLAIN:_____

OTHER THAN THE SERVICES WE HAVE ALREADY PROVIDED FOR YOU, WHAT ADDITIONAL SERVICES WOULD YOU LIKE TO LEARN ABOUT? PLEASE CHECK ALL THAT APPLY.

___SKIN CARE PRODUCTS SUCH AS GLYMED ___CROW'S FEET ___DROOPING BROW

___FROWN LINES ___FACIAL FULLNESS/DROOPING ___FACIAL FINE LINES/WRINKLES

___DROOPING EYELIDS ___NOSE SIZE OR SHAPE ___DERMAL FILLERS ___CHEMICAL PEEL

___BOTULINUM TOXIN TYPE A (BOTOX/XEOMIN)

PLEASE ANSWER THE FOLLOWING QUESTIONS ON A SCALE OF 1 TO 5 BY CIRCLING THE APPROPRIATE NUMBER.

WHEN LOOKING AT MY FACE IN THE MIRROR, I BELIEVE I LOOK YOUNGER, THE SAME AS, OR OLDER THAN MY TRUE AGE.

YOUNGER THAN		TRUE AGE		OLDER THAN
1	2	3	4	5

WHEN LOOKING IN THE MIRROR, I AM NOT CONCERNED, SOMEWHAT CONCERNED, OR VERY CONCERNED ABOUT THE APPREARANCE OF MY WRINKLES.

NOT CONCERNED		SOMEWHAT		VERY CONCERNED
1	2	3	4	5

___WOULD YOU LIKE TO HAVE INFORMATION ON PRODUCTS AND SERVICES, INCLUDING SPECIAL OFFERS EMAILED TO YOU?

EMAIL ADDRESS: _____

___I AM NOT INTERESTED IN ANY ADDITIONAL SERVICES AT THIS TIME.

I CONFIRM THAT ALL OF THE ANSWERS TO THE QUESTIONNAIRE ARE TRUE AND CORRECT. I WILL NOTIFY THE LIFETIME HEALTH CENTER IF ANY CHANGES IN MEDICIATIONS, TREATMENTS, OR MEDICAL HISTORY.

PATIENT SIGNATURE:_____ DATE:_____

CONSULTING MEDICAL PROFESSIONAL SIGNATURE:_____ DATE:_____

MEDICAL DIRECTOR SIGNATURE:_____ DATE:_____

THE LIFETIME HEALTH CENTER OFFERS MANY MORE OTHER MEDICAL SERVICES. PLEASE SEE OUR WEBSITE, www.lifetimehealthcenter.com, OR ASK A MEDICAL PROVIDER FOR MORE INFORMATION.

THIS FORM MUST BE COMPLETED FOR ALL NEW PATIENTS AND EXISTING PATIENTS WHOSE LAST TREATMENT WAS 1 YEAR AGO OR MORE.