FLAWLESS IMAGE MEDICAL AESTHETICS, LLC

5805 Bridge Street, East Syracuse, NY 13057 • (315) 694-6243

NAME _____ TODAY'S DATE _____

Birthdate _____ Age_____ Occupation _____

Street _____City_____State_____Zip _____

Phone _____ Email _____

Primary Care Doctor_____

How did you hear about our office? _____

Please list the <u>name, street address, and city</u> of your pharmacy below:

_____

Please tell us what you are most concerned about when it comes to aging and your physical appearance?

_____

_____

List all exercise, physical activities and frequency (Hobbies, sports, etc.): _____

_____

HEALTH HISTORY

1. Do you currently consider yourself to be in good health? .....YES / NO

2. Height_____Weight_____

3. Have there been any changes in your general health in the past year? .....YES / NO

4. Are you under the care of a physician?.....YES / NO .....Date of last visit:_____
   If so, for what are you being treated?_____

5. Have you had any illnesses, operation or been hospitalized in the past five years? .....YES / NO
   If so, please describe:_____

6. Do you have a prosthetic joint/implant? .....YES / NO .....If so, where: _____

7. Have you ever had a heart valve replacement or vascular graft?.....YES / NO

HAVE YOU HAD, OR DO YOU CURRENTLY HAVE:	Y	N	NOTES
1. Rheumatic Fever?			
2. Damaged Heart Valve/Mitral Valve Prolapse?			
3. Heart Murmur?			
4. High Blood Pressure?			
5. Low Blood Pressure?			
6. Chest Pain/Angina/Heart Attack(s)			
7. Irregular Heartbeat?			
8. Cardiac Pacemaker?			
9. Heart Surgery?			
10. Bronchitis/Cough/Emphysema?			
11. Asthma?			
12. Snoring/Sleep Apnea?			
13. Difficulty Breathing/Other Lung Problems?			
14. Tuberculosis?			
15. Do You Smoke?			
16. Blood Disorder, such as Anemia?			
17. Do You Bruise Easily?			
18. Bleeding Tendency/Abnormal Bleeding?			
19. Hepatitis, Jaundice, or Liver Disease?			
20. Gall Bladder Problems?			
21. Fainting Episodes?			
22. Convulsions/Epilepsy?			
23. Stroke?			
24. Thyroid Problems?			
25. Diabetes?			
26. Low Blood Sugar?			
27. Kidney Problems?			
28. Are You on Dialysis?			
29. Swollen Ankles, Arthritis or Joint Disease?			
30. Stomach Ulcers?			
31. Contagious Diseases?			
32. Sexually Transmitted Diseases?			

HAVE YOU HAD, OR DO YOU CURRENTLY HAVE:	Y	N	NOTES
33. Are You taking any Immunosuppressant Drugs (steroids)?			
34. Problems with Immune System? Possibly from Medication/ Surgery, etc?			
35. Healing Problems?			
36. A Tumor or Growth?			
37. Radiation Therapy/ Chemotherapy?			
38. Chronic Fatigue/Night Sweats?			
39. A History of Drug Abuse?			
40. A History of Alcohol Abuse?			
41. Contact Lenses?			
42. Eye Disease/Glaucoma?			
43. Mental Health Problems?			
44. A Removable Dental Appliance?			
45. Pain/Clicking of Jaw when Eating?			
46. Malignant Hyperthermia?			
47. Scar Problems?			
48. Anesthesia Problems?			

FOR FEMALE PATIENTS ONLY: (QUESTIONS 49-52)
49. Is there a possibility of pregnancy?……..YES / NO
50. Are you taking birth control pills?…….. YES / NO
51. Are you using other forms of birth control?…..YES / NO
52. Are you nursing?……..YES / NO

MEDICATIONS

ARE YOU NOW TAKING:	Y	N	NOTES
53. Any Kind of Medication, Drug or Pills? **List Below**			
54. Blood Thinners? (Coumadin, Plavix, Aspirin, Vitamin E, Ginko Biloba, Aggrenox, Pradaxa, Fish Oil) **List Below**			
55. Have You Ever Taken Diet Pills?			
56. Any Natural Product, Herbal Supplement, or Homeopathic Remedy?			
57. Are You Taking, or Have You Ever Taken Bone Density Medications, Such as Fosamax, Boniva, Actonel? **List Below**			
58. Tranquilizers, Sleeping Pills, Anti-Depressants, and/or Narcotics on a Regular Basis? **List Below**			

59. LIST ALL MEDICATIONS THAT YOU ARE CURRENTLY TAKING:

THE PURPOSE OF MY CONSULT TODAY IS TO DISCUSS	Y	N	NOTES
71. Weight Loss			
72. CoolSculpting			
73. Smart Lipo			
74. Laser Skin Resurfacing			
75. Botox			
76. Wrinkle Fillers			
77. Laser Hair Removal			
78. Tattoo Removal			

ALLERGIES

ARE YOU ALLERGIC TO OR HAD A REACTION TO:	Y	N	NOTES
60. Local Anesthesia (Numbing Medications)?			
61. Penicillin, Amoxicillin, Sulfa Drugs or other Antibiotics?			
62. Sedatives or Anesthesia Medications?			
63. Aspirin/Ibuprofen/Other NSAIDS?			
64. Codeine or Other Narcotics?			
65. Latex?			
66. Soy?			
67. Eggs/Yolk?			
68. Sulfites?			

69. LIST ANY OTHER MEDICATION/ANTIBIOTIC YOU ARE ALLERGIC TO:

70. LIST ANY ALLERGIES OTHER THAN DRUG ALLERGIES

THE PURPOSE OF MY CONSULT TODAY IS TO DISCUSS	Y	N	NOTES
79. Microneedling			
80. Other - Describe Below			

By signing this notice I acknowledge that HIPPA Privacy Practices have been made available to me and I understand that all medical information will be kept confidential.

Patient Signature (Responsible party)_____

Printed Name_____ Date _____