



COSMETIC HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential and will become part of your medical record

Cosmetic Surgery Clinics

Patient Name _____ MR# _____
 Today's Date _____

PERSONAL INFORMATION	
Name (Last, First, M.I.)	<input type="checkbox"/> M <input type="checkbox"/> F DOB (mm/dd/yyyy)
Street Address	Home Phone
City, State, Zip	Work Phone
SS#	Occupation/Employer
Driver's License #	Race/Ethnicity
Marital Status:	<input type="checkbox"/> Single <input type="checkbox"/> Partnered <input type="checkbox"/> Married <input type="checkbox"/> Separate <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed
Spouse/Partner Name	DOB (mm/dd/yyyy)
Phone	Occupation/Employer
Parent/Guardian's Name (If under 18)	
Emergency Contact (Other than Spouse)	Relationship
Address	Phone
What are you here for today?	
Have you consulted any other doctor about this?	<input type="checkbox"/> Yes <input type="checkbox"/> No Optional: Please list his/her name(s)
COSMETIC HISTORY	
EYE Color	<input type="checkbox"/> Blue <input type="checkbox"/> Green <input type="checkbox"/> Hazel <input type="checkbox"/> Grey <input type="checkbox"/> Light Brown <input type="checkbox"/> Dark Brown
HAIR Color	<input type="checkbox"/> Blonde <input type="checkbox"/> Red <input type="checkbox"/> Light Brown <input type="checkbox"/> Medium Brown <input type="checkbox"/> Dark Brown <input type="checkbox"/> Black <input type="checkbox"/> Grey/Silver <input type="checkbox"/> White
SKIN Tone	<input type="checkbox"/> Pale/White <input type="checkbox"/> Light <input type="checkbox"/> Reddish/Freckles <input type="checkbox"/> Light Olive <input type="checkbox"/> Medium Olive <input type="checkbox"/> Dark Olive <input type="checkbox"/> Brown <input type="checkbox"/> Black
Check all SKIN TYPES that apply to your skin:	<input type="checkbox"/> Normal <input type="checkbox"/> Uneven, Blotchy <input type="checkbox"/> Large Pores <input type="checkbox"/> Cystic <input type="checkbox"/> Perfumed-Stained <input type="checkbox"/> Oily <input type="checkbox"/> Mature Wrinkled <input type="checkbox"/> Small Pores <input type="checkbox"/> Melasma <input type="checkbox"/> Dry <input type="checkbox"/> Wrinkled <input type="checkbox"/> Acne <input type="checkbox"/> Flurid <input type="checkbox"/> Hypopigmented <input type="checkbox"/> T-Zone, Combination <input type="checkbox"/> Sagging <input type="checkbox"/> Milia <input type="checkbox"/> Rosacea <input type="checkbox"/> Freckled <input type="checkbox"/> Firm <input type="checkbox"/> Sun Damaged <input type="checkbox"/> Comedones <input type="checkbox"/> Asphyxiated <input type="checkbox"/> Occasional Breakouts <input type="checkbox"/> Scarred <input type="checkbox"/> Sallow <input type="checkbox"/> Post-Inflammatory Hyperpigmented
Do you consider your skin:	<input type="checkbox"/> Sensitive <input type="checkbox"/> Resilient

Do you consider your skin:	◆ Fair (Burns easy in sun)	◆ Moderate (Burns occasionally in sun)	◆ Dark (Do not burn)
Do you go to tanning booths?	◆ Yes ◆ No s		
Do you get facial waxing, electrolysis, or use depilatories?	◆ Yes ◆ No s		
Have you ever had collagen or other filler injections?	◆ Yes ◆ No s		
If yes, please explain and describe your reaction:			
Have you ever had a peel?	◆ Yes ◆ No s		
If yes, please explain and describe your reaction:			
Have you ever had BOTOX treatments?	◆ Yes ◆ No s		
If yes, please explain and describe your reaction:			

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COSMETIC HISTORY CONTINUED								
Have you ever had laser treatments?			◆ Yes ◆ No					
If yes, please explain and describe your reaction:								
Are you using any of the following:								
Retin A? ◆ Yes ◆ No	How frequently?	Where do you apply it?						
Accutane? ◆ Yes ◆ No								
Hormones/other medication? ◆ Yes ◆ No	If yes, which one(s)?							
Glycolic/AHA home care products? ◆ Yes ◆ No	If yes, which one(s)?							
Alpha-hydroxy acid? ◆ Yes ◆ No	If yes, which one(s)?							
How does your skin react to the above products?								
Have you had a bad reaction to any products? ◆ Yes ◆ No			Describe:					
Check any to which you are ALLERGIC	◆ Milk	◆ Apples	◆ Citrus	◆ Grapes	◆ Aloe Vera	◆ Aspirin	◆ Hydroquinone	◆ Eggs
	◆ Other:							
Have you had liposuction? ◆ Yes ◆ No								
If yes, note region: ◆ Abdomen ◆ Outer Thigh ◆ Inner Thigh ◆ Neck ◆ Knees ◆ Breast ◆ Buttocks ◆ Ankles								
Have you had breast surgery? ◆ Yes ◆ No				If yes, note type: ◆ Reduction ◆ Augmentation ◆ Reconstruction				
If reduction	Scar pattern: ◆ Periareolar ◆ Horizontal & Periareolar ◆ Vertical & Periareolar ◆ Horizontal, Vertical & Periareolar							
If augmentation	Date:	Position: ◆ Submuscular ◆ Subglandular ◆ Dual Plane						
	Size:	Approach: ◆ Inframammary Crease ◆ Periareolar ◆ Arm Pit						
		Implant: ◆ Saline ◆ Silicone						
If reconstruction	Date:	Type:						
Have you had facial implants? ◆ Yes ◆ No			If yes, date:		Position: ◆ Chin ◆ Jaw ◆ Cheeks			
Please list any cosmetic surgery not specified above:								
Any blood in your urine or stool? ◆ Yes ◆ No								

Any recent weight change? If yes, note increase or decrease amount:	◆ Yes	◆ No
Do you ever get nose bleeds?	◆ Yes	◆ No
Do you bruise easily?	◆ Yes	◆ No
Do you have a history of Oral Herpes (such as cold sores)?	◆ Yes	◆ No
Any vascular disease (such as Scleroderma, Raynaud's, Buerger's Disease)?	◆ Yes	◆ No

Please sign below to certify that all information provided on this Cosmetic History Questionnaire (Pages 1 and 2) is true and accurate to the best of your knowledge:

Patient Name (please print) _____ Date _____

Parent/Guardian (please print) _____ Signature _____

A photocopy of these assignments shall be as valid as the original

Patient Name _____ MR# _____
Date _____

PHYSICIAN NOTES – SHADED SECTION BELOW FOR OFFICE USE ONLY

PHYSICAL EXAM

Height	Weight	Blood Pressure

A/P

Physician Signature

Date