PATIENT INFORMATION/MEDICAL HISTORY

IN ORDER TO PROVIDE YOU WITH THE MOST APPROPRIATE TREATMENT, WE NEED YOU TO COMPLETE THE FOLLOWING QUESTIONNAIRE. ALL INFORMATION IS STRICTLY CONFIDENTIAL.

PERSONAL INFORMATION

NAME:_____

DOB:_____

ADDRESS:_____

PHONE:_____ EMAIL:_____

OK TO TEXT MESSAGE: **YES** / **NO** OK TO LEAVE VOICEMAIL: **YES** / **NO**

PREFERRED CONTACT METHOD: CALL / TEXT MESSAGE / EMAIL

EMERGENCY CONTACT:_____PHONE**:**_____

HEALTH HISTORY

MEDICATION **(**PRESCRIPTION, OVER THE COUNTER; VITAMINS, HERBAL SUPPLEMENTS**)**

_____

_____

ALLERGIES:_____

HAVE YOU EVER HAD AN ALLERGIC REACTION TO THE FOLLOWING?

FOOD ANIMAL PROTEIN ASPIRIN LIDOCAINE HYDROCORTISONE
EGSS LATEX HYDROQUINONE OR SKIN BLEACHING AGENTS
OTHERS:_____

HISTORY OF: (PLEASE MARK **YES** OR **NO** TO ALL)

HEART DISEASE	Y / N	BLOOD CLOTTING ABNORMALITIES	Y / N
HYPERTENSION	Y / N	NEUROMUSCULAR DISEASE	Y / N
HIV/AIDS	Y / N	AUTOIMMUNE DISEASE	Y / N
DIABETES	Y / N	HEPATITIS	Y / N
COLD SORES	Y / N	CANCER	Y / N
SEIZURE	Y / N	KELOID SCARRING	Y / N

OTHER:_____

_____

FACIAL HISTORY

HAVE YOU HAD ANY DENTAL WORK IN THE PAST TWO WEEKS? YES / NO

DO YOU HAVE ANY DENTAL WORK SCHEDULED IN THE NEXT TWO WEEKS? YES / NO

DO YOU REQUIRE ANTIBIOTIC PROPHYLAXIS PRIOR TO DENTAL WORK? YES / NO

HAVE YOU EVER HAD BOTOX/WRINKLE RELAXER OR DERMAL FILLERS? YES / NO

IF YES, WHAT DID YOU HAVE DONE AND WHEN WERE YOU LAST TREATED?

_____

ANY COMPLICATIONS? YES / NO IF YES, PLEASE SPECIFY:_____

FACIAL INJURY TRAUMA HISTORY

IS THERE ANY HISTORY OF FACIAL SURGERY? YES / NO
DESCRIBE:_____

IS THERE ANY RECENT HISTORY OF TRAUMA TO THE HEAD OR FACE? YES / NO
DESCRIBE:_____

DO YOU HAVE ANY PERMANENT IMPLANTS IN YOUR FACE? YES / NO
DESCRIBE:_____

ANY TMJ PROBLEMS? PAIN CLENCHING GRINDING
DESCRIBE:_____

ANYTHING ELSE YOU WISH TO TELL US?

_____

_____

I ATTEST TO THE BEST OF MY KNOWLEDGE I AM NOT PREGNANT, I AM NOT ACTIVELY TRYING TO GET PREGNANT, I AM NOT LACTATING (NURSING) AND I DO NOT HAVE AN ACTIVE SKIN LESION IN AREA(S) BEING TREATED

THE ABOVE INFORMATION IS TRUE AND ACCURATE TO THE BEST OF MY KNOWLEDGE AND AGREE TO INFORM PROVIDER OF ANY CHANGES IN THE ABOVE INFORMATION

_____

PATIENT SIGNATURE **DATE**

KANISHKA PATEL MD