UTAH FACIAL PLASTICS

Transformation you can Trust

Medical History

Name: _____ Date of Birth:_____

What is your main symptom or reason for this visit?_____

Are you allergic to any medications, latex or tape? ☐ Yes ☐ No

If so, please list:_____

List all current medications including prescriptions (with dosage), over-the-counter meds, and vitamins:

_____ _____ _____

_____ _____ _____

_____ _____ _____

Have you recently taken medication containing aspirin or ibuprofen (Advil/Motrin)? ☐ Yes ☐ No

If so, please list last date and dose: _____

Have you been on steroid or Accutane therapy in the last 18 months? ☐ Yes ☐ No

If so, please list last date and dose: _____

Are you currently pregnant or nursing? ☐ Yes ☐ No Date of most recent pregnancy: _____

Do you smoke cigarettes, or use tobacco products? ☐ Yes ☐ No If so, how much per day:_____

Do you consume alcoholic beverages? ☐ Yes ☐ No If so, how many per week:_____

Have you recently taken any recreational drugs? ☐ Yes ☐ No If so, list last date: _____

Exercise Frequency (check one): ☐ None ☐ 1x/week ☐ 2-3 x/week ☐ 4-6 x/week

List all past medical and cosmetic surgeries (include dates if possible): _____

_____ _____ _____

_____ _____ _____

Have you ever had any surgical or anesthesia complications? ☐ Yes ☐ No

If so, please describe: _____

Please list any concerns that you may have regarding your surgery or procedure:_____

_____

Cosmetic Patients:

What area(s) of the face are you interested in having cosmetically or functionally improved?

☐ Upper or Lower Eyelids
☐ Placement of Brow/ Heavy Brow
☐ Ears
☐ Nose
☐ Lips/ Thinning or Uneven
☐ Cheek/ Midface
☐ Lower Face/ Nasolabial Folds
☐ Chin/ Jaw Line/ Jowls
☐ Neck / Neck Bands
☐ Skin Texture or Pigmentation
☐ Wrinkles
☐ Other:

Which procedures or services are you interested in learning more about?

☐ Botox
☐ Fillers (Restylane, Juvederm, Radiesse)
☐ Rhinoplasty
☐ Blepharoplasty
☐ Face Lift
☐ Brow Lift
☐ Neck Lift
☐ Prescription Skin Care
☐ Laser Pigment Treatment (Fotofacial)
☐ Laser Hair Removal
☐ Chemical Peels (Deep or Superficial)
☐ Other: _____

Have you ever received Botox or injectable fillers such as Restylane, Juvederm, or Radiesse? ☐ Yes ☐ No

Do you have family and or a significant other's support in your cosmetic decisions? ☐ Yes ☐ No

Please list current skincare products & topical medications including type of sunscreen if used:_____

_____ _____ _____

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Please check past and present medical conditions:

CARDIOVASCULAR:

- ☐ High Blood Pressure
- ☐ Heart attack(s)
- ☐ Heart Disease
- ☐ Coronary artery disease
- ☐ Heart murmur/ Mitral valve
- ☐ Irregular heartbeat/ palpitations
- ☐ Stroke
- ☐ Peripheral vascular/ arterial disease
- ☐ Blood Clots

PULMONARY:

- ☐ Asthma
- ☐ Pneumonia
- ☐ Chronic lung Disease
- ☐ Chronic cough
- ☐ Shortness of breath
- ☐ Sleep Apnea

NEUROMUSCULAR:

- ☐ Muscle Weakness
- ☐ Nerve Damage
- ☐ Facial paralysis / weakness
- ☐ Seizure disorder / convulsions
- ☐ Spinal/ back disorders
- ☐ Arthritis

ENDOCRINE:

- ☐ Diabetes
- ☐ Thyroid disease
- ☐ Significant weight loss or gain (circle)

RENAL:

- ☐ Dialysis
- ☐ Renal failure

GASTROINTESTINAL:

- ☐ Cholecystitis
- ☐ Colitis
- ☐ Pancreatitis
- ☐ Reflux disease
- ☐ Stomach ulcers

HEMATOLOGICAL:

- ☐ Blood transfusion
- ☐ Bleeding disorder
- ☐ Easy bruising

IMMUNOLOGICAL/ INFECTIOUS:

- ☐ HIV / AIDS
- ☐ TB
- ☐ Autoimmune disorder:

HEPATIC:

- ☐ Cirrhosis
- ☐ Hepatitis

CANCER:

- ☐ Breast cancer
- ☐ Family history of cancer
- ☐ Basal cell cancer
- ☐ Squamous cell cancer
- ☐ Melanoma
- ☐ Other cancer

Family History of Serious Illness:

_____
_____
_____
_____
_____

PSYCHOLOGICAL:

- ☐ Depression
- ☐ Anxiety
- ☐ Claustrophobia
- ☐ Receive(d) psychiatric treatment
- ☐ Drug/ alcohol dependency treatment
- ☐ Psychiatric hospitalization

NOSE:

- ☐ Nasal allergies
- ☐ Difficulty breathing through nose
- ☐ Previous nasal injury
- ☐ Previous nasal surgery
- ☐ History of sinus infections

EYES:

- ☐ Dry eyes
- ☐ Blurred/ double vision
- ☐ Cornea problems
- ☐ Glaucoma
- ☐ Thyroid eye disease
- ☐ Wear glasses / contacts

DERMATOLOGICAL:

- ☐ Cold sores / herpes
- ☐ Acne
- ☐ Rosacea
- ☐ Eczema
- ☐ Radiation to face / neck
- ☐ Scarring / keloid formation

HEIGHT _____

WEIGHT_____

BLOOD PRESSURE_____

Please list any other significant illness or conditions_____