



Cosmetic Medical History

All questions contained in this questionnaire are strictly confidential and will become part of your medical record. All questions must be answered. Failure to do so will result in an inaccurate medical record and may affect your insurance processing.
PLEASE ASK if you have any questions.

Date: ___/___/___

Your Name: (Last, First, MI) _____ Date of Birth: ___/___/___ Age: ___

How do you identify yourself: (Place an "X") Male ___ Female ___ Other ___

Pharmacy – Name: _____ Location: _____

PLEASE CIRCLE BELOW ALL MEDICAL DIAGNOSES YOU HAVE:

PAST MEDICAL HISTORY					
Anemia	Arterial Disease	Arthritis	Asthma	B12 Deficiency	Cancer of: _____
Diabetes	Heart Disease/Congestive Heart Failure	Hepatitis/Liver Disease	HIV	Hole in Heart	Hypertension
Kidney Disease	Lung Disease	Lymphedema	MEN2	Migraines	Pacemaker
Papillary Thyroid Cancer	Restless Legs	Stroke	OTHER: _____ _____	Neurological Disorders	

PLEASE CIRCLE THE ANSWER THAT FITS YOU – FEMALES ONLY:

PAST MEDICAL HISTORY: PREGNANCY/NURSING HISTORY						
QUESTION	ANSWERS					
1. Are you nursing?	Yes	No				
2. Are you planning more children?	Yes	No				
3. Are you Pregnant?	Yes	No	If yes, which Trimester?	First	Second	Third
4. How many pregnancies have you had?	# _____	How many C-sections?	# _____	How many Vaginal Deliveries?	# _____	
5. Have you had a blood clot from pregnancy?	Yes	No				
6. Are you taking birth control pills?	Yes	No	If no, have you taken them in the past?	Yes	No	
7. Are you taking Hormone Replacement Therapy?	Yes	No	If no, have you taken them in the past?	Yes	No	

PLEASE **CIRCLE** ALL THE CONDITIONS/SURGERIES YOU HAVE HAD (FEMALE CONTINUED):

Fibroids	Endometriosis	C-Section	Hysterectomy	Ovary Removal
Ovarian Cysts	Myomectomy	Uterine Ablation	OTHER: _____	

PAST SURGERIES – NON VEIN	
SURGERY	YEAR
PAST VEIN SURGERIES	
SURGERY (STRIPPING, LASER, ETC.)	YEAR

PLEASE **PLACE AN "X" IN** THE ANSWER THAT FITS YOUR FAMILY:

FAMILY HISTORY					
CONDITION	MOTHER	FATHER	BROTHER	SISTER	OTHER FAMILY
Rosacea					
Acne					
Melanoma or skin cancers					

PLEASE FILL IN THE BLANKS AND **CIRCLE** THE ANSWER THAT FITS YOU:

SOCIAL HISTORY					
1. OCCUPATION:					
2. Are you retired?	Yes	No			
3. Do you drink alcohol?	Yes	No	If yes, how many times have you had more than 4 drinks in one day in the past year?	____ # of times more than 4 drinks in one day	
4. Do you smoke?	Yes	No	If yes, do you smoke: (circle)	less than 9 cig/day	Greater than 10 cig/day
5. Do you use chewing tobacco?	Yes	No			
6. If you smoke:	What age did you start? age_____	How many packs per day? _____packs/day	Have you thought about quitting?	Yes	No
7. If you are a FORMER Smoker:	How long did you smoke? _____years	At what age did you start? age_____	How packs per day? _____packs/day		
8. Marital Status?	Married	Unmarried	Divorced	Widowed	Other_____

9. Do you have children?	Yes	No	If yes, how many children? _____		
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CURRENT MEDICATIONS (please include all over the counter and supplements)		
Name	Strength	Frequency (how often)

ALLERGIES		
Medication/Food	Type of reaction (rash, hives, etc.)	CIRCLE severity of reaction
		mild moderate severe
		mild moderate severe

FITZPATRICK CLASSIFICATION SYSTEM (Please circle which applies)

SKIN TYPE	SKIN COLOR	CHARACTERISTICS
I	White	Always burns, never tans
II	White	Usually burns, never tans
III	White	Sometimes mild burn, tans about average

SKIN TYPE	SKIN COLOR	CHARACTERISTICS
IV	White	Rarely burns, tans more than average
V	Brown	Rarely burns, tans perfectly
VI	Black	Never burns, deeply pigmented

For Skin Conditions/Concerns: (wrinkles, rosacea, pores, redness, etc.)

Have you seen a dermatologist for your skin? []Yes []No

Have you ever had laser treatments, microdermabrasion or peels? []Yes []No If so, when? _____

Have you ever had Botox/ fillers? []Yes []No If so, when and location of treatments: _____

Have you ever had skin cancer? If yes, where and what treatments? _____

Do you have rosacea? []Yes []No If yes, what have you tried and for how long? _____

Do you have acne? []Yes []No Is it cystic? []Yes []No Do you have scars? []Yes []No

What have you tried in the past?(creams, Accutane, treatments, etc.) _____

What type of skin products are you using now? _____

What are you concerned about with your skin? (wrinkles, pores, dryness, oily, etc.) _____

Do you have an implanted device? Pacemaker, stimulator, etc.? If yes, where? _____

For Hair Reduction:

What color is the hair of concern: _____ What area needs treatment: _____

Do you shave? [] Yes [] No Do you pluck? [] Yes [] No Do you use a cream for hair removal? [] Yes [] No

For Tattoo Removal:

When did you get your tattoo? _____ Location(s) on body of tattoo to be removed _____

Please circle Yes/No:

Black Tattoo	Yes	No	Keloid Scars	Yes	No	Tanning within the last 6 weeks	Yes	No	Did you have an allergic reaction to your tattoo?	Yes	No	Hypersensitivity to skin products	Yes	No
Color Tattoo	Yes	No	Hives	Yes	No	Use of acne products/drugs	Yes	No	Steroid use?	Yes	No	Skin infections	Yes	No
Professional Ink	Yes	No	Skin Cancer	Yes	No	Photo sensitizing substances	Yes	No	Any Previous Tattoo Removal	Yes	No	Homemade Ink	Yes	No
Waxing	Yes	No	Cold sores	Yes	No	Needle phobia?	Yes	No	Autoimmune medications?	Yes	No	Electrolysis to area	Yes	No

For TruBody (Trusculpt and Truflex) Treatments:

Are you looking for fat reduction AND/OR muscle building? _____

Areas you would like treated? Please circle below:

Lower Abdomen	Upper Abdomen	Right Flank	Left Flank
Back	Bra Bulge	Arms	Front of Legs
Back of Legs	Inner Thighs	Outer Thighs	Buttocks

Have you had treatments to these areas before? If yes, when: _____

For Brella (Sweat Reduction Patch treatments):

Is this you? (circle yes or no for all questions please)

I have to reapply deodorant during the day.	YES	NO
I shy away from wearing white/light-colored and/or silk shirts because they show my sweat stains.	YES	NO
I need to change to a clinical strength deodorant because the regular strength didn't seem to work.	YES	NO
I worry about my underarm sweat when I am talking in front of other	YES	NO

people or giving a presentation, as it may be noticeable.		
I am interested in learning more about the newest treatment to reduce underarm sweat, Brela.	YES	NO

For Weight Loss:

	YES	NO
Do you ever feel like your eating patterns can get out of control?		
Do you eat in between meals?		
Do you have any dietary restrictions?	If yes, which restrictions? _____	
Do you currently have a physical activity routine?		
Have you been on a weight loss medication in the past?	If yes, which medication? _____	
Are you currently on a weight loss medication?	If yes, which medication? _____	
Do you have a gym membership?		
Do you have a therapist?	If yes, which type of therapist? _____	

PLEASE CIRCLE ALL THAT APPLIES:

What type of physical activity do you participate in:

- a. Walking
- b. Aerobics Class/Exercise
- c. Weight Training
- d. Running
- e. Nothing

How long does the physical activity last:

- a. 30 min
- b. Greater than 30 minutes
- c. Less than 30 minutes

How often do you participate in physical activity:

- a. Daily
- b. 3 times a week
- c. 5 times a week
- d. Greater than 5 times a week

How many weight loss attempts have you tried in the past 5 years:

- a. 0
- b. 1
- c. 2
- d. 3
- e. Greater than 3

Thank you for providing this important information about your medical history. Please be advised that completing preliminary health and insurance questionnaires does not establish a physician-patient relationship with this practice. Dr. Aggarwal and the staff will review your health history and conduct an initial evaluation to determine whether you are a suitable candidate and whether the practice will accept you as a patient.

Responsible Party Signature: _____ **Date:** _____

Relationship to Patient (if other than self): _____