

**Genesis Cosmetic Surgery Center & Medical Spa  
Patient Health/Skin History Form**

Name \_\_\_\_\_

Today's Date \_\_\_\_\_

Name of Person Filling out Form \_\_\_\_\_

Relation \_\_\_\_\_

*Please fill out the information below to provide us with background on your personal health history. This information will remain confidential and will be part of your patient record. Thank you.*

Date of Birth \_\_\_\_\_ Age \_\_\_\_\_  Male  Female Marital Status (circle) S M D W

Occupation \_\_\_\_\_

Height \_\_\_\_\_

Weight \_\_\_\_\_

Primary Care Physician \_\_\_\_\_

Referred by \_\_\_\_\_

**Procedures I would like to discuss with the doctor:**

**Breast:**  Augmentation  Reduction  Lift  Reconstruction Bra Size \_\_\_\_\_

**Facial Rejuvenation:**  Necklift  Facelift  Eyelid Correction  Forehead/Brow Lift  Skin rejuvenation

**Nasal Surgery:**  Corrective  Cosmetic

**Contour Correction:**  Liposuction  Tummy Tuck  Body Lift  Arm Lift

**Spider Veins:**  Face  Legs

**Ancillary Procedures:**  Botox  Wrinkle correction  Laser  Chemical peels  Hair replacement

**Other:** \_\_\_\_\_

Please indicate in your own words what concerns you: \_\_\_\_\_

Past Medical History: (please list all illnesses): \_\_\_\_\_

Allergies (please list): \_\_\_\_\_

Current Medications (please list medication name, dosage, include vitamins, minerals, natural supplements, over the counter drugs): \_\_\_\_\_

Prior Surgery (operation and year): \_\_\_\_\_

Have you had a problem with anesthesia?  Yes  No If yes, please explain \_\_\_\_\_

Hospitalizations (please list dates and reason): \_\_\_\_\_

Family History (please circle or list): skin cancer, breast cancer, heart disease, diabetes, alcoholism, anesthesia problems

Do you or have you ever smoked?  Yes  No If yes, how many packs per day? \_\_\_\_\_

How many years have you smoked? \_\_\_\_\_ Have you quit?  Yes  No When? \_\_\_\_\_

Do you exercise?  Yes  No If so, how much? \_\_\_\_\_

Do you drink alcohol?  Yes  No If so, how much? \_\_\_\_\_

If applicable, are you pregnant now?  Yes  No Past pregnancies?  Yes  No # pregnancies \_\_\_\_\_ # living children \_\_\_\_\_

**PLEASE COMPLETE ON BACK**

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**Please check the circle that applies:**

- yes no Cardiac:**
- Heart murmur
  - Chest pain
  - Hypertension
  - Irregular heart beat
  - Mitral valve prolapse
  - Rheumatic fever
  - Heart attack
  - Swelling of legs
  - Leg cramps with walking
  - High cholesterol
  - Blood clots

- yes no Respiratory:**
- Seasonal allergies
  - Difficulty breathing
  - Shortness of breathing
  - History of facial trauma
  - Nose bleeds
  - Asthma
  - Snoring
  - Trouble breathing thru nose

- yes no Breast:**
- Breast cancer
  - Breast pain
  - Neck pain
  - Back pain
  - Shoulder grooves
  - Skin irritation
  - Asymmetry
  - Sagging

- yes no Eyes:**
- Watery eyes
  - Dry eyes
  - Corrective eyewear
  - Lasik surgery

- yes no General:**
- Thyroid problems \_\_\_\_\_
  - HIV
  - Recent weight gain \_\_\_\_\_
  - Recent weight loss \_\_\_\_\_
  - Rheumatoid arthritis
  - Autoimmune diseases
  - Hepatitis
  - Lupus
  - Depression
  - Anxiety
  - ADHD
  - Anemia

- yes no Neurologic :**
- Stroke
  - Seizures
  - Head injury
  - Migraine eadaches
  - Fainting/blackouts

- yes no Skin:**
- Herpes (cold sores)
  - Skin cancer
  - Eczema
  - Rosacea
  - Acne
  - Pigmentation problems

**FOR SKIN EVALUATION PATIENTS ONLY: Please check the circle that applies below:**

**Conditions you would like improved:**

- Wrinkles, where \_\_\_\_\_  Pigmentation problems  Acne, active  Rosacea  Acne scarring  Scars, other  
 Large pores  Other \_\_\_\_\_

**Sun exposure:**

- Past:  Little  Excessive  
 Present:  Little  Excessive

**Tanning Beds:**

- Past:  Little  Excessive  
 Present:  Little  Excessive

**Sunscreen:**

- Never  Occasional  Daily

**yes no Have you ever had or used:**

- Retin A
- Chemical peels
- Microdermabrasion
- Laser, type \_\_\_\_\_
- Botox
- Restylane
- Collagen or other tissue filler
- Accutane
- Herpes medication
- Antibiotics for skin
- Oral contraceptives

**Current skin care regimen:**

- Cleanser \_\_\_\_\_  
 Toner \_\_\_\_\_  
 Scrub \_\_\_\_\_  
 Exfoliator \_\_\_\_\_  
 Sunscreen \_\_\_\_\_  
 Moisturizer \_\_\_\_\_  
 Other \_\_\_\_\_

PATIENT SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_ PHYSICIAN INITIALS \_\_\_\_\_