The Aesthetic Center

At Barbara Ioannides Rappaport, MD, PA

Today's Date_____

Name_____

Date of Birth_____ Occupation_____

Home Address_____
City_____ State_____ Zip Code_____

Home Phone (____) _____ Cell Phone (_____) _____

Do you smoke? YES NO

Regular Exercise? YES NO Type: _____

Email Address:
_____

Emergency Contact Name and Phone:
_____

Pharmacy Name/ Phone:
_____

Whom should we thank for referring you? _____

Procedures / products of interest to you:

□ BOTOX Cosmetic (Botulinum Toxin Type A)

□ Skin Care Advice

□ Skin Care Products

□ Sunscreen Advice

□ Facials and Eye Treatments

□ Laser Resurfacing

□ Virtually Painless Hair Removal

□ Liver Spots/Age Spots

□ Acne scarring

□ Spider Vein

□ Rosacea / Facial Veins

□ ClearLift Plus "lunchtime face lift"

□ Other, please specify _____

History of Cosmetic/Aesthetic Procedures:

YES NO Have you ever had any facial surgery performed? TYPE: _____

YES NO Have you ever had any type of Chemical Peel? TYPE: _____

YES NO Have you ever had any type of laser treatment including laser hair removal? TYPE: _____

YES NO Have you had any recent tanning or sun exposure that changed the color of your skin? TYPE: _____

YES NO Have you recently used any self-tanning lotions or treatments? TYPE: _____
Have you ever had any of the following injectable procedures done? (circle) Botox Juvederm Restylane Radiesse Collagen Sculptra Other_____

Fitzpatrick Skin Type: (circle one)

I Always burns, never tans

II Always burns, sometimes tans

III Sometimes burns, always tans

IV Rarely burns, always tans

V Brown, moderately pigmented Skin

VI Black skin

YES NO Are you currently under the care of a physician (for other than annual exams?) If YES for what: _____

YES NO Are you currently under the care of a dermatologist? If YES for what: _____

Do you have any of the following medical conditions?

□ NONE

□ Cancer □ Diabetes □ High blood pressure □ Herpes/cold sores □ Arthritis □ HIV/AIDS or other immunosuppressive diseases □ Skin disease □ Seizure Disorder □ Hepatitis □ Hormone Imbalance/PCOS □ Any Active Infections □ Herpes Simplex, Lupus, or Porphyria □ Rosacea □ Thyroid Imbalance □ Blood clotting/bleeding abnormalities

Do you have any other health problems or medical conditions (not listed)?

_____

_____

YES NO Do you have any allergies to ANY medications? (Please list ALL & TYPE of reaction)

_____

_____

Please list ALL medications (including OTC / herbal supplements) you are currently taking.

□ NONE □ Birth control pills □ Hormones □ Others (please list)

_____

Please list all Topical Medications / Skin Care Creams you are currently taking.

_____

YES NO Are you currently using □ Aspirin, □ NSAIDS (Motrin, Advil, Aleve), □ Plavix (clopidogrel), □ Coumadin (warfarin), □ Pradaxa, □ Eliquis, or □ Lovenox (heparin) ?

YES NO Have you ever used Accutane (isotretinoin)? If yes, when did you last use?

_____

Do you have any of the following specific allergies?

YES NO Lidocaine/ Novocain?

YES NO Hydroquinone or skin bleaching agents?

YES NO Hypersensitivity to Latisse (Bimatoprost)?

YES NO Botulinum toxin (Botox) products?

YES NO Gram-positive bacterial proteins?

If you circled “YES” to any of the above, please explain here:

_____

Do you presently have or have you had a history of any of the following conditions?

YES NO Have any autoimmune disorders?

YES NO Any disease that affects muscles and nerves?

YES NO Amyotrophic lateral sclerosis [ALS or Lou Gehrig's disease]?

YES NO Myasthenia gravis / Lambert-Eaton syndrome?

YES NO Scleroderma or other connective tissue disease?

YES NO Are you on immunosuppressive therapy?

YES NO Have had radiation therapy?

YES NO Bleeding problems?

YES NO Breathing problems, such as asthma or emphysema?

YES NO Drooping eyelids? (other than natural aging)

YES NO Do you have history of any eye pressure problems / macular edema?

YES NO Have a pacemaker or internal defibrillator?

YES NO Herpes infections, bacterial or fungal infections in the areas to be treated?

YES NO History of epilepsy?

YES NO Side effects from any Botulinum toxin product in the past?

YES NO Do you form thick or raised scars (keloids) from cuts or burns?

YES NO Hyperpigmentation (darkening of the skin) or Hypopigmentation (lightening of the skin)?

YES NO Areas of persistent redness?

YES NO Are you using medications that make you sensitive to light?

YES NO Are you using preparations containing sulfur, resorcinol, or salicylic acid

YES NO Do you have a history of anaphylaxis/severe allergies?

Women only:

YES NO Are you using contraception?

YES NO Pregnant or plan to become pregnant?

YES NO Breast-feeding or plan to breastfeed?

If you circled “Yes” to any of the above, please explain here:

_____

_____

_____

I certify that the preceding medical, personal and skin history statements are true and correct. I am aware that it is my responsibility to inform the aesthetician, therapist, nurse, or doctor of my current medical or health conditions and to update this history. Patient Signature_____ Date _____

Reviewed with patient by_____ Date _____