FACEOLOGYMD
EXPERIENCE BEAUTY

Patient Profile

Patient Name:_____Today's Date:_____/_____/_____

Date of Birth:_____/_____/_____ Age:_____ Gender: Female Male

Your Contact Information

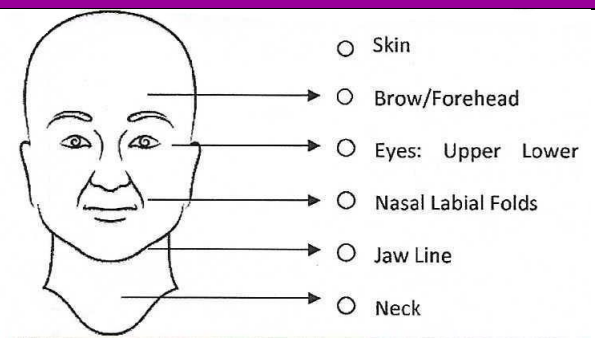
Phone Number _____ Mobile Phone Number _____

Email Address _____

Mailing Address:_____

Who should we contact in case of an emergency?
(name/number)_____

Tell Us What Matters Most to You (Check all that apply)



How long have these areas been of concern to you?

_____

_____

_____

Were you referred to see us? If so, who referred you?_____

Privacy Statement

At **FACEOLOGYMD**, we value your privacy. In order to protect the privacy of our patients it is the policy of this office to prohibit the use of sound, video and other electronic recording devices, including cell phone cameras. The use of such devices is a violation of the right to privacy of both our patients and employees. By signing below, you agree that such conduct is an invasion of the privacy of others and will refrain from using recording devices.

Agree and Acknowledged

_____ _____
Patient Signature Date

____ **Initial** I hereby acknowledge that a copy of the *Notice of Privacy Practices* has been made available to me (to be given at office)**.**

I authorize Dr. Raymond E. Lee to contact me or leave medical information pertaining to my care. Please check the following methods:

____ Home phone ____ Cell Phone ____ Email

1401 Avocado Ave, Suite 610 | Newport Beach, CA 92660
www.faceologymd.com | info@faceologymd.com
t: 949.706.2277 | f: 949.706.2279

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Medical History

Patient Name: _____ Today's Date: _____/_____/_____

Your Contact Information

Please respond to the following questions:

Is walking up a flight of stairs with a bag of groceries difficult for you?	☐ Yes	☐ No
Are you currently pregnant?	☐ Yes	☐ No
Are you currently undergoing radiation therapy or chemotherapy for cancer?	☐ Yes	☐ No
Have you ever had a connective tissue disorder such as Ehlers Danlos Syndrome, Lupus, Scleroderma, Rheumatoid Arthritis, Wegener's Disease or Sarcoidosis?	☐ Yes	☐ No
Have you had surgery of the face or neck within the previous 6 months?	☐ Yes	☐ No
Oxygen dependent COPD or severe asthma?	☐ Yes	☐ No
Bleeding Disorder?	☐ Yes	☐ No
Abnormal Scarring?	☐ Yes	☐ No
Reaction to latex?	☐ Yes	☐ No
Lidocaine allergy?	☐ Yes	☐ No
Epinephrine sensitivity?	☐ Yes	☐ No
Currently taking Coumadin, Aspirin, Plavix, Pradaxa or other anticoagulant (blood thinner)?	☐ Yes	☐ No
Brain aneurysm or brain shunt?	☐ Yes	☐ No
Prior parotidectomy (salivary gland removal)?	☐ Yes	☐ No
OBSTRUCTIVE SLEEP APNEA?	☐ Yes	☐ No
Do you have Restless Leg Syndrome?	☐ Yes	☐ No
HIV/AIDS?	☐ Yes	☐ No

Kidney insufficiency?	☐ Yes	☐ No
Liver insufficiency, cirrhosis or active hepatitis?	☐ Yes	☐ No
Blood clots or Pulmonary Embolism?	☐ Yes	☐ No
Diabetes that requires medication?	☐ Yes	☐ No
High Blood Pressure (hypertension)?	☐ Yes	☐ No
Heart disease or heart problems?	☐ Yes	☐ No
Have you ever had an aortic aneurysm?	☐ Yes	☐ No
Angina or chest pain w/exercise?	☐ Yes	☐ No
Angioplasty and/or stent placement?	☐ Yes	☐ No
Have you had a heart attack within the past 12 months?	☐ Yes	☐ No
Do you have a pacemaker or AICD?	☐ Yes	☐ No
Heart Catheterization/stress test? ☐ Normal Date:_____ ☐ Abnormal	☐ Yes	☐ No
Have you ever had a stroke or TIA?	☐ Yes	☐ No
Are you a current smoker?	☐ Yes	☐ No
Severe dry eyes?	☐ Yes	☐ No
Limited neck mobility?	☐ Yes	☐ No
Have you taken the medication Accutane within the past 12 months?	☐ Yes	☐ No

If you answered yes to any of the above, please provide details below, and indicate the name of the specialist physician that is treating this condition, as well as the last time that you saw this physician. Please also list anything Dr. Raymond Lee should know about your medical health or any special concerns. Please include recent illnesses that required hospitalization, recent contact with your physician, or new medications or antibiotics.

_____

_____

_____

Family Physician: _____ Phone Number_____

Date of last exam: _____/_____/_____

(Continued)

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Cardiologist's Name (if applicable) _____ Phone Number_____

Date of last exam: _____/_____/_____

May we contact your physician(s) in order to obtain a medical clearance if necessary? ___Yes ___No

Pharmacy_____ Phone Number_____

A Little Bit More About You

Please list any surgeries you have had:

_____

_____

_____

What medications or supplements (prescribed and non-prescribed) are you currently taking?

Medication:	Dosage & Frequency:

Please list any medications that you are allergic to and describe the reaction, if any.

Medication:	Type of Reaction:

I certify that I have listed all of my current medications, allergies, hospitalizations, medical conditions and previous surgeries to the best of my knowledge and ability.

_____ _____

Signature Date

Medical history confirmed as up-to-date: _____ _____

Surgeon's Initial Date (Must be day of procedure)

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Supplemental Medical History Form
For Laser Treatment

Patient: _____ Date: _____

IPL/ Laser History

1. Please list previous types, dates and body locations:

_____
_____

Additional Medical History

1. Have you had or have you ever been exposed to hepatitis? ___Yes ___No

2. Do you have a disease that is stimulated by light or heat such as epilepsy? ___Yes ___No

3. Have you ever received local or topical anesthesia (novocaine or lidocaine) by a dentist or doctor?

___Yes ___No

If yes, and you experienced a reaction, please describe:

_____
_____

4. (Women) Are you currently breastfeeding? ___Yes ___No

Skin Type

1. Ethnicity: (Please check)

___White ___Asian ___Hispanic ___Mediterranean ___Middle Eastern ___Black ___Combination

2. When you go out in the sun, do you burn or tan? ___Burn ___Tan

3. Which of the following best describes your skin reaction when you are in the sun? (Please circle)

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

Skin

1. Have you ever had skin cancer? ___Yes ___No

2. Have you ever had fillers (e.g. - Restylane) injected? ___Yes ___No

3. Have you ever taken the medication ACCUTANE? ___Yes ___No

4. Do you have a history of cold sores? ___Yes ___No

(Continued)

5. Do you have a Connective Tissue Disorder or any specific skin diseases? ___Yes ___No

6. Have you ever had excessive scarring or keloid formation? ___Yes ___No

7. Have you ever had impaired healing? ___Yes ___No

8. Have you ever had melasma? ___Yes ___No

9. Do you have any tattoos, tattoo makeup or beauty marks? ___Yes ___No

If yes, please list

location(s):_____

10. Do you have any pigment problems (brown or white areas)? ___Yes ___No

If yes, please list

location(s):_____

11. Please list any other diseases/conditions not previously listed here or on other forms:

_____

Social History

1. Do you drink alcohol? ___Yes ___No If yes, _____ drinks per week

2. Do you smoke? ___Yes ___ No If yes, how much: _____

3. Do you plan to take a vacation in the near future? ___ Yes___No

4. Do you wear sunscreen? (check one) ___Never ___Sometimes ___Always

5. What SPF do you wear? _____ How often do you apply sunscreen? _____

6. What skin care products do you use?

_____

_____

Completed by:

Patient: _____ _____
Signed by patient Date

Medical Assistant/Doctor: _____ _____ _____
(Initials) Reviewed By Date

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Eye Questionnaire

Patient Name:_____ Date:_____

Date of last eye exam:_____

Name and address of practitioner who performed your eye exam:_____

_____

1. Do you wear glasses/ contacts? ___Yes ___No
2. Do you have a history of glaucoma or other eye disorders? ___Yes ___No
3. Have you ever had an injury to or surgery of the eyes or eyelids? ___Yes ___No
4. Do you have frequent irritation of the eyes or eyelids? ___Yes ___No
5. Do you now take or have you ever taken medications or drops for the eyes? ___Yes ___No
6. Are you bothered by dry eyes? ___Yes ___No
7. Do your eyes tear excessively? ___Yes ___No
8. Do you have or ever had visual problems with one or both eyes? ___Yes ___No
9. Do you have detached retina? ___Yes ___No
10. Are there any eye problems we may not have asked about that you believe we should know about?

Please explain any "Yes" answers above:

_____

_____

_____

Test performed (check one) **with** or **without** glasses/ contacts:

1. Cover your right eye and read the sentence below with your left eye.

Are you able to read it comfortably? ___Yes ___No

2. Cover your left eye and read the sentence below with your right eye.

Are you able to read it comfortably? ___Yes ___No

3. Is there any difference in your vision? Please indicate:

Both eyes the same?___ Right eye stronger___ Left eye stronger___

I signify that the information provided is correct to the best of my knowledge.

Signed (Patient):_____

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