



Patient Profile

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

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

Your Contact Information

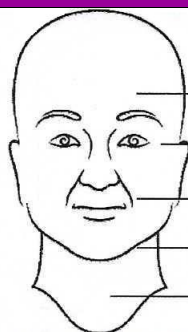
Phone Number _____ Mobile Phone Number _____

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)



- ☐ Skin
- ☐ Brow/Forehead
- ☐ Eyes: Upper Lower
- ☐ Nasal Labial Folds
- ☐ Jaw Line
- ☐ Neck

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



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)



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)



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 | IV. Rarely burns; always tans |
| II. Always burns; sometimes tans | V. Brown, moderately pigmented skin |
| III. Sometimes burns; always tans | 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 _____



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): _____