



SAN FRANCISCO UNION SQUARE
 166 GEARY STREET, SUITE 1502
 415.445.9513

EAST BAY PINOLE
 1700 SAN PABLO AVENUE, SUITE F
 510.724.6662

www.yourfaceinourhands.com

Medical History

Name

 First Last Middle

Medical

<i>Do you have or had:</i>	Yes	No		Yes	No
Prolonged bleeding	<input type="checkbox"/>	<input type="checkbox"/>	Fainting or blackouts	<input type="checkbox"/>	<input type="checkbox"/>
Vision Deficits	<input type="checkbox"/>	<input type="checkbox"/>	Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>
Dry Eyes	<input type="checkbox"/>	<input type="checkbox"/>	Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	Chest Pain	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Liver Disease	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Other, if so describe		<input type="checkbox"/>

Surgical

Previous Operations:

Medications

Name	Dosage (if known)	Name	Dosage (if known)
_____	_____	_____	_____
_____	_____	_____	_____

Do you or have you taken: Yes No
 Aspirin or Ibuprofen Accutane? _____ Date _____
 Coumadin (Warfarin) Tretinoin? _____ % _____
 Steroids in the past year

Allergies

None If Yes, please list: _____

**Scarring/
Other**

Have you formed excessive or unsatisfactory scars in the past? Yes No

Do you have herpes simplex? (fever blisters) _____
 Birth Control Pills? _____ Currently Pregnant? _____
 Breast Feeding _____ Attempting Pregnancy? _____

**Personal
Physician**

Name of regular physician: _____ Specialty: _____
 Date of last physical examination: _____
 Business Telephone: () _____ - _____

Family History

Is there a history of the following in your immediate family? If so, please list the family member beside the disease.

	No	Yes	
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	Family member: _____
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	Family member: _____
Anesthesia Reaction	<input type="checkbox"/>	<input type="checkbox"/>	Family member: _____

Personal History

Do you smoke?: No Yes, _____ pack(s) per day.