Fine Arts
SKIN & LASER
FACIAL PLASTIC SURGERY

## PERSONAL INFORMATION

Last Name _____First Name _____Middle Initial_____

Address _____

City _____State_____Zip Code _____

Preferred Contact Number _____ May we leave a detailed message? __ Yes __ No

Email Address: _____

___ Please check here if you do NOT want to receive our Exclusive Web Offers and Private Invitations by email.

Date of Birth: _____ Gender: ___ Female ___ Male

Family Doctor: _____ Preferred Pharmacy: _____

Emergency Contact: _____ Phone: _____

How did you hear about us? _____ If an individual told you about us, may we thank them? Yes No

| SOCIAL/PERSONAL HISTORY: | EXPLANATION: |
|---|---|
| Do you smoke or use tobacco/nicotine products? | |
| Do you drink alcohol? If yes, how much/often? | |
| Do you use recreational drugs? | |
| Do you have bleeding, bruising or clotting problems? | |
| Do you have issues with scarring? | |
| Do you have any history or problems with anesthesia? | |

| COSMETIC PROCEDURE HISTORY: | DATE: |
|---|---|
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## MEDICAL HISTORY

### PLEASE CHECK ALL MEDICAL CONDITIONS PAST OR PRESENT:

| | YES | NO | | YES | NO |
|---|---|---|---|---|---|
| Cold sores | | | High blood pressure | | |
| Herpes | | | Pacemaker | | |
| Easy bruising or bleeding | | | Skin Cancer | | |
| Skin infection | | | Photosensitive disorder (i.e. lupus) | | |
| Moles that have recently changed, itched, or bled | | | Disease of nerves or muscles (i.e. ALS, Myasthenia gravis, Lambert- Eaton or other) | | |
| Recent increase in amount of hair | | | Seizures | | |
| Asthma | | | Cancer | | |
| Allergies | | | HIV/AIDS | | |
| Eczema | | | Heart Condition | | |
| Thyroid imbalance | | | Hepatitis | | |
| Poor healing | | | Shingles | | |
| Diabetes | | | Migraines | | |
| Autoimmune disease (i.e. rheumatoid arthritis, scleroderma) | | | Other illness, health problems, or medical conditions not listed | | |
| Currently/Possibly Pregnant | | | Breastfeeding | | |
| Thick or raised scars after injury to skin (such as burns/cuts) | | | Darkening of skin in areas of injury (such as burns/cuts) | | |
| Lightening of skin in areas of injury (such as burns/cuts) | | | Accutane or anticoagulants in the last 6 months | | |

Do you have ANY allergies to medications, food, latex, or other substances? If yes, please list and describe reaction:

_____

Do you take/use ANY medications or topicals on a regular or daily basis? If yes, please list:

_____

_____

Do you have any permanent make-up, implants, or tattoos? __ Yes __ No

If yes, please list locations: _____

Have you had any unprotected sun exposure, used tanning creams/sprays, or tanning beds in the last 4-6 weeks?
__ Yes __ No If yes, please describe: _____

I certify that the information I have given is complete and accurate.

I hereby authorize Fine Arts Skin and Laser and its providers to proceed with any medical treatment.

I understand that I am responsible for any charges incurred at Fine Arts Skin and Laser.

I acknowledge that I have been offered to receive a copy of the practice privacy policies.

I would like a written copy of Fine Arts Skin and Laser privacy policies. ____Yes ____No

Signature: _____ Date: _____