Anti-Aging Questionnaire

Patient Name: ______________________________ **Date:** __________________

1. **What are your main concerns/goals from this consultation?**
   ____
   ____

2. **List all drug allergies (including food/tape/latex allergies):**
   ____________________ ____________________ ____________________

3. **List all medications you are taking: (Prescriptions, Narcotics, Over-the-Counter, Vitamins & Herbs)**
   ____________________ ____________________ ____________________
   ____________________ ____________________ ____________________

4. **List all past surgeries (including cosmetic surgeries) with dates:**
   ____________________ ____________________ ____________________

5. **Did you experience any complications?** No Yes, Explain: ______________________________

6. **Have you been on Accutane, Amnesteem, Isotretinoin, or Claravis therapy in the last 12 months?** Yes No Ever

7. **Are you pregnant or trying to conceive?** **Yes** **No**

8. **Do you Have Any of the Following:** Permanent Make Up, If Yes, Areas: ______________ Metal Stents
   Implanted Electrical Devices Cochlear Implants Bell's Palsy Facial Implants Dental Implants

9. **Have you ever had gold therapy?** **Yes** **No**

10. ***Please check all past and present medical conditions***

Heart	**Cancer**	**Special**		**Neuro**
High blood pressure	Basal cell cancer	Pacemaker	Claustrophobia	Lou Gehrig's
Heart attack	Squamous cell cancer	Defibrillato	Lupus	ALS
Coronary artery disease	Malignant melanoma	Hip Implant	Hyperpigmentation	Myasthenia Gavis
Eyes	Other______________	Dental Implant	Vitiligo	Lambert Eaton Syndrome
Dry eyes	**Hormonal**	History of Scarring	Hepatitis	Bell's Palsy
Blurred vision	Diabetes	Cold sores/herpes	HIV/AIDS	Stroke
Wear glasses/contacts	Thyroid disease	Keloid		Multiple Sclerosis

11. **Are you considering cosmetic surgery in the future?**
    □ No □ Yes Please Explain: ______________________________

12. **Is a short period of unsightliness or discomfort or swelling an option?**
    □ No problem □ Not Possible □ 1-3 Days □ 3-7 Days

13. **Have you ever had any of these?** □ Yes □ No

°Botox®	□ Satisfied	□ Unhappy	Radiesse®	□ Satisfied	□ Unhappy
°Juvederm®	□ Satisfied	□ Unhappy	Sculptra®	□ Satisfied	□ Unhappy
°Restylane®	□ Satisfied	□ Unhappy	Fat	□ Satisfied	□ Unhappy

If you were unhappy with any of the above, please tell us why: ______________________________

14. **Lifestyle issues (please check all that apply):**

Do you smoke?	□ No	□ Yes, in the past	□ Yes, Currently
Do you use tanning beds?	□ No	□ Yes, in the past	□ Yes, Currently
Do you use sunscreen?	□ No	□ Yes, in the past	□ Yes, Currently
Do you take hormone replacement therapy?	□ No	□ Yes, in the past	□ Yes, Currently

15. **I exercise ______ times a week. I drink _____ glasses of water a day. I eat _____ servings of fruits/vegetables a day**

16. **List your daily skin care routine (please include products used):**
    AM: ______________________________ **PM:** ______________________________