NEW PATIENT AESTHETIC HEALTH QUESTIONNAIRE

Cape Fear Eye Aesthetics
For internal use only

NAME _____ TODAY'S DATE _____

DATE OF BIRTH _____ AGE _____ SEX _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

EMAIL _____ PHONE _____

HOW DID YOU HEAR ABOUT US? _____

PLACE A CHECKMARK IF YOU ARE CURRENTLY BEING TREATED FOR OR HAVE A HISTORY OF ANY OF THE FOLLOWING MEDICAL CONDITIONS:

- ☐ Myasthenia Gravis
- ☐ Multiple Sclerosis
- ☐ Lambert Eaton Syndrome
- ☐ Bell's Palsy
- ☐ ALS
- ☐ Neuromuscular Disorder
- ☐ Stroke
- ☐ Head injury
- ☐ Facial injury
- ☐ Neck injury
- ☐ Hepatitis
- ☐ Skin Cancer
- ☐ Radiation
- ☐ HPV
- ☐ HIV/AIDS
- ☐ Alcohol Use
- ☐ Drug Use
- ☐ Tobacco Use
- ☐ Anxiety
- ☐ Depression
- ☐ Bipolar Disorder
- ☐ Epilepsy/ Seizures
- ☐ Dizziness
- ☐ Migraines/Headaches
- ☐ Raynaud's Syndrome
- ☐ Heart Disease
- ☐ Heart Attack
- ☐ High Blood Pressure
- ☐ Poor Circulation
- ☐ Excessive Bleeding
- ☐ Respiratory Problems
- ☐ Muscle Spasms/Cramps
- ☐ Fibromyalgia
- ☐ Autoimmune Disorder
- ☐ Diabetes
- ☐ LIDOCAINE ALLERGY
- ☐ ANAPHYLAXIS
- ☐ Vitiligo/Rosacea

MEDICATION ALLERGIES:

_____

_____

_____

MEDICATIONS-Please include all topical, over the counter medications, herbal/holistic remedies, & supplements:

_____

_____

_____

PLACE A CHECKMARK IF YOU HAVE HAD ANY OF THE FOLLOWING IN THE LAST 7-10 DAYS:

- ☐ Aspirin
- ☐ Ibuprofen
- ☐ Motrin
- ☐ Warfarin/Blood thinners
- ☐ Fish Oil
- ☐ Ginkgo
- ☐ Vitamin E
- ☐ Antibiotics
- ☐ Retinol or Retin-A
- ☐ Vitamin A derivative products
- ☐ Hydroquinone
- ☐ Accutane

Do you drink alcohol? **Yes** **No**

Do you smoke or use tobacco products? **Yes** **No**

History of tanning bed use? **Yes** **No**

Have you been tanning (bed, UV, spray) within the last 4 weeks? **Yes** **No**

Do you see a dermatologist? **Yes** **No** Who? _____ Date last seen? _____

Are you being treated for any skin conditions on your face? _____

_____

Do you have acne? **Yes** **No** Does it occur randomly or around your cycle (if female)? _____

Do you get cold sores? **Yes** **No** Keloid scars? **Yes** **No** If so, from minor scratches or cuts? **Yes** **No**

Have you ever had facial surgery? If so, describe: _____

Have you ever had botulinum toxin injections? **Yes** **No** Date of last treatment _____

Were you pleased with the results? _____

Have you ever had dermal filler injections? **Yes** **No** Date of last treatment _____

Were you pleased with the results? _____

Are you undergoing any hormone replacement therapy? If so, please specify: _____

Have you ever had any lymph nodes removed? If so, please specify: _____

FOR FEMALE PATIENTS:

Is there a chance you could be pregnant? **Yes** **No**
Are you lactating? **Yes** **No**
Are you trying to become pregnant? **Yes** **No**
Do you use birth control? **Yes** **No**

Model Agreement for Website and/or Social Media:
I agree to allow Cape Fear Eye Aesthetics to use '**Before and After photos' Note:** Eyes will be covered by black box to protect identity (*Please initial one*).
_____ Full Face
_____ Individual Area
_____ NO PERMISSION

***Photo Disclaimer: Please note 'all' patients will have photos taken to monitor your clinical progress. Initialing 'No Permission' only pertains to website and/or social media usage.**

SKINCARE

Have you ever had a facial treatment before? _____

Which of the following best describes your skin type? (Place a checkmark by one skin type)

- ☐ I - Always burns easily, never tans
- ☐ II - Always burns, tans slightly
- ☐ III - Burns moderately, tans gradually
- ☐ IV - Seldom burns, always tans well
- ☐ V - Rarely burns, deep tan
- ☐ VI - Rarely burns, deeply pigmented

Do you have any special skin problems or concerns pertaining to your face or body? _____

If so, please specify _____

Have you ever had chemical peels, microdermabrasion, or laser treatments? **Yes** **No** In the last month? **Yes** **No**

What skincare products do you currently use? (*List brand name where known*).

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

I hereby certify that I have filled out the Health Questionnaire and that it is accurate and true to the best of my knowledge.

_____ _____ _____
Patient Signature **Provider Signature** **Date**

SELF ASSESSMENT

What would you like to achieve from your treatment or procedure?

_____

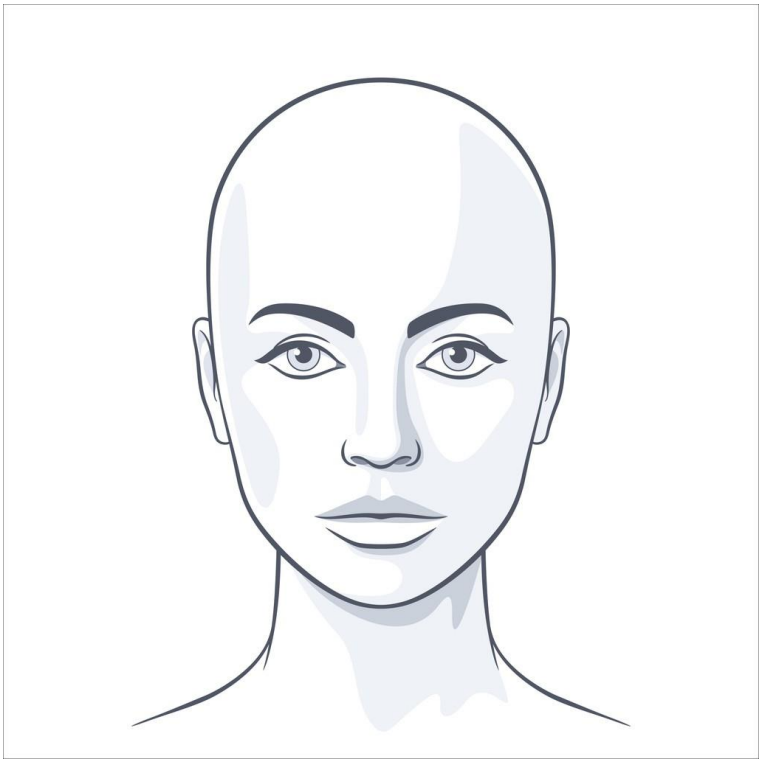
Do you have a special occasion or event coming up? _____

What areas of concern do you have regarding your skin?

☐ Breakouts/acne	☐ Broken capillaries	☐ Dull or dry skin
☐ Blackheads/whiteheads	☐ Sun spot/liver spot/brown spot	☐ Flaky skin
☐ Excessive oil/shine	☐ Uneven skin tone	☐ Dehydrated
☐ Redness or ruddiness	☐ Sun damage	☐ Dark circles under eyes
☐ Rosacea	☐ Wrinkles/fine lines	☐ Other _____

Select which areas of the face concern you on the diagram below.

By sharing how you see yourself, we can best evaluate your aesthetic goals and select an appropriate treatment plan for you.



Additional Patient Skin Concerns:

_____

_____

_____

_____

Provider Treatment Plan:

_____

_____

_____

_____

_____