Kathy L. Anderson, DO, PA

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Patient Name: ____ Date of Birth: _____/_____/_____

Chief Complaint: ____ Today's Date: _____/_____/_____

PLEASE CHECK THE BOX FOR THE CONDITIONS YOU HAVE NOW OR HAVE HAD IN THE PAST:

- ❒ Acne
- ❒ Alcoholism
- ❒ Anemia
- ❒ Anorexia
- ❒ Appendicitis
- ❒ Arthritis
- ❒ Asthma
- ❒ Bleeding Disorder
- ❒ Breast Lump
- ❒ Cancer
- ❒ Chemical Dependency
- ❒ Chicken Pox - Age: __
- ❒ Dermatitis
- ❒ Diabetes
- ❒ Eczema
- ❒ Emphysema
- ❒ Epilepsy
- ❒ Gout
- ❒ Hair/Nail Disorder
- ❒ Heart Disease
- ❒ Hepatitis
- ❒ Herpes
- ❒ High Blood Pressure
- ❒ High Cholesterol
- ❒ HIV Positive/AIDS
- ❒ Hormone Changes
- ❒ Kidney Disease
- ❒ Liver Disease
- ❒ Measles
- ❒ Melanoma
- ❒ Menopause
- ❒ Moles
- ❒ Pacemaker
- ❒ Pneumonia
- ❒ Pre-Cancerous Lesions
- ❒ Pre-Menopausal
- ❒ Rosacea
- ❒ Skin Cancer
- ❒ Stroke
- ❒ Thyroid Problem
- ❒ Tuberculosis
- ❒ Ulcers
- ❒ Warts
- ❒ Other _____________
- ❒ Any other medical condition ___________________

SURGICAL HISTORY: (Date and Procedure) ____

____

Do you have allergies to medications or foods? If so, please list: ______________________________

Allergy to Neomycin (Neosporin): ❒ YES ❒ NO
Allergy to Lidocaine/Novocaine: ❒ YES ❒ NO
Allergy to Latex: ❒ YES ❒ NO
Allergy to Epinephrine: ❒ YES ❒ NO

MEDICATION LIST:	DOSAGE	FREQUENCY

Do you take aspirin, aspirin like products or blood thinners? ❒ YES ❒ NO

Who is your Primary Care Physician? ______________________________ **Phone Number** __________________

GENERAL

Tobacco Use:	❒ Socially	❒Weekly	❒ Daily	❒ Never	❒Quit – If so, how long ago ___________
Alcohol Use:	❒ Socially	❒Weekly	❒ Daily	❒ Never	❒Quit – If so, how long ago ___________
Recreational Drugs:	❒ Socially	❒Weekly	❒ Daily	❒ Never	❒Quit – If so, how long ago ___________
Caffeine Intake:	❒ 1 – 2 Cups	❒ 3+ Cups	❒ Occasionally	❒Rarely	❒Never

HAS ANY BLOOD RELATIVE HAD ANY OF THE FOLLOWING?

- ❒ Actinic Keratosis (Pre-Cancer)
- ❒ Basal Cell Carcinoma
- ❒ Cancer
- ❒ Diabetes
- ❒ Eczema
- ❒ High Blood Pressure
- ❒ Malignant Melanoma
- ❒ Psoriasis
- ❒ Skin Cancer
- ❒ Squamous Cell Carcinoma

FEMALE PATIENTS ONLY:

Are you currently?

Taking birth control: ❒ YES ❒ NO
Pregnant: ❒ YES ❒ NO
Breast Feeding: ❒ YES ❒ NO
Taking hormone replacement: ❒ YES ❒ NO

Please complete the back of this form

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COSMETIC INTEREST QUESTIONNAIRE

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

HEALTH ISSUES AND PROCEDURES OR PRODUCTS OF INTEREST TO YOU (*PLEASE CHECK ALL THAT APPLY*)

- ❒ Acne
- ❒ Acne Scarring
- ❒ Anti-Aging Treatments
- ❒ Birthmarks
- ❒ BOTOX® Cosmetic
- ❒ Cellulite Treatment
- ❒ Chemical Peels
- ❒ Facial Veins Treatments
- ❒ Facial Waxing
- ❒ Hair Removal
- ❒ Juvederm™
- ❒ Laser Resurfacing
- ❒ Liver Spots/Age Spots
- ❒ Microdermabrasion
- ❒ Radiesse®
- ❒ Radio Frequency
- ❒ Restylane®
- ❒ Sculptra™
- ❒ Skin Care Advice
- ❒ Skin Care Products
- ❒ Skin Rejuvenation
- ❒ Skin Tightening
- ❒ Spider Vein Treatments
- ❒ Sunscreen Advice

❒ Other, please specify: ____

HAVE YOU PREVIOUSLY HAD ONE OF THE FOLLOWING?

BOTOX® Cosmetic	❒ YES ❒ NO	Areas Treated: ______________________________	Date: ____________
Chemical Peel	❒ YES ❒ NO	Type of Peel: ______________________________	Date: ____________
Cosmetic Fillers	❒ YES ❒ NO	Areas Treated: ______________________________	Date: ____________
		Type of Filler: ____	
Facial Surgery	❒ YES ❒ NO	Procedure: ______________________________	Date: ____________
Laser Resurfacing	❒ YES ❒ NO	Type/Depth: ______________________________	Date: ____________
Microdermabrasion	❒ YES ❒ NO		

What sunscreen products do you currently use? Face: ______________________ Body: ____________________

What skin care products do you use frequently? ____

HOW DO YOU TAN?

- ❒ **I** Burn
- ❒ **II** Usually Burn
- ❒ **III** Sometimes Burn
- ❒ **IV** Rarely Burn
- ❒ **V** Never Burn – "Brown"
- ❒ **VI** Never Burn – "Black"

FACIAL WRINKLES:

- ❒ Deep Wrinkles
- ❒ Crow's Feet
- ❒ Fine Lines
- ❒ Peri-oral Lines (around the mouth)

SKIN TYPE:

Does your skin ever flake and feel tight and dry?	❒ Frequently	❒Occasionally	❒Very Rarely
Is your skin ever dry a few hours after cleansing?	❒ Frequently	❒Occasionally	❒Very Rarely
How often do you experience blackheads or blemishing?	❒ Frequently	❒Occasionally	❒Very Rarely
How noticeable are your pores?	❒Very	❒ T-Zone	❒Not Very