22455 N. Miller Rd.
Scottsdale, AZ 85255
Office #: (480) 686-8121 Fax#: (480) 686-8425

History and Physical

Patient Name:_____ Today's Date:_____

Date of Birth:_____/_____/_____ (MM/DD/YYYY) Age:_____

Gender: F M (please circle)

Address: _____ City/State/Zip:_____

Home Phone:_____ Cell Phone:_____

Work Phone:_____ Email Address:_____

Emergency Contact:_____ Phone:_____ Relationship:_____

Primary Care Physician:_____ Phone Number:_____

Purpose of Visit/Interests

☐ **Liposuction** ☐ Fat Transfer ☐ Breasts ☐ Buttocks ☐ Other: _____ ☐ **Stem Cell-Enriched**

☐ **Facial Rejuvenation** ☐ Facial Volume Enhancement ☐ Fillers: (Please Circle) Nose, Lips, Eyes, Mid Face, Other

☐ **SmartXide Laser Skin Resurfacing** ☐ Face ☐ Neck ☐ Chest ☐ Other_____ ☐ Acne Scars

☐ **Skin Care** ☐ Photofacials ☐ Microdermabrasion ☐ Acne treatment ☐ Mole Removal ☐ Hair Reduction

☐ **Vein Treatment** ☐ Varicose Veins ☐ Spider Veins **Other:**_____

Chief concern/complaint: (List Below)

Pertinent past medical history: (List Below)

Previous surgeries (cosmetic or other): (Please include dates)

Medical History:

Do you smoke?	yes	no
Do you have a chronic cough?	yes	no
Any complications with previous surgeries? (List Below)	yes	no
Heart problem, heart murmur, or irregular beat?	yes	no
Facial paralysis or Bell's Palsy?	yes	no
High blood pressure?	yes	no
Hepatitis or liver disease?	yes	no

Excessive tearing, dryness or allergic reaction to eyes?	yes	no
Asthma or COPD?	yes	no
Snoring or Obstructive Sleep Apnea?	yes	no
Have you ever had a formal sleep study?	yes	no
Do you have long periods of not breathing while asleep as noted by your partner?	yes	no
Do you use a CPAP machine?	yes	no
Do you find yourself falling asleep in the middle of the day?	yes	no
Abdominal or inguinal hernias?	yes	no
Kidney or thyroid problems?	yes	no
Previous back or nerve injury?	yes	no
History of seizure, neurological, or phychiatric problems?	yes	no
History of blood clots in legs or lungs? Leg swelling?	yes	no
History of transfusion or positive HIV test?	yes	no
Are you pregnant or possibly pregnant?	yes	no
Do you have Raynaud's disease, lupus, scleroderma, or other collagen vascular disease?	yes	no
Do you have diabetes?	yes	no
History of autoimmune disorder?	yes	no
Have you taken Accutane? If so, when?	yes	no
Date of your last menstrual cycle?		
Child Births: Number of C-Sections:_____ Number of Vaginal Births_____		
Any family history of complications from ANY type of anesthesia?	yes	no
Have you had problems with excessive scar formation?	yes	no
Have you had problems with excessive or unexplained bleeding?	yes	no
Have you ever had MRSA or been close to someone who has?	yes	no
Do you have any other medical history or concerns we have not addressed? (List below)	yes	no

Referral Information

How did you hear about us?

- ☐ TV What Channel?_____
- ☐ Internet
- ☐ Magazines
- ☐ Mail Interests
- ☐ Driving By
- ☐ Walk In
- ☐ Other_____
- ☐ Patient Referral/Word of Mouth: _____
- ☐ Physician Referral: _____

I hearby agree all the above information is correct to the best of my knowledge.

_____ _____

Patient Signature **Date**

_____

Print Name