Patient Health/Skin History Form

Name ____ Date _________________________

Address: ______________________________ City: _______________State: ______Zip: ____________

Phone Number: ______________________ Email: ____

Date of Birth_______________ Age_______ Sex_______ Height_________ Weight________

Primary Care Physician: ____

How did you hear about us? _____________________________________

Procedures I would like to discuss

Facial Rejuvenation: **Facelift** **Necklift** **Browlift** **Facial Fat Grafting**

Nasal Surgery: **Cosmetic Rhinoplasty** **Septum Problems**

Profile: **Chin Implant** **Cheek Implant** **Neck Liposuction** **Kybella**

Eyelid Surgery: **Upper Blepharoplasty** **Lower Blepharoplasty**

Skin Rejuvenation: **Moles** **Wrinkles** **Brown Spots** **Sun Damage** **Acne Scars** **Laser Resurfacing**

Injectables: **Botox** **Juvederm** **Voluma** **Radiesse** **Restylane** **Lip Augmentation**

Please indicate, in your own words, your concerns and what you would like to improve:

____

Have you ever used any of the following:

Retin A	**Y**	**N**	**Silicone, Sculptra, Bellafill**	**Y**	**N**
Chemical Peels	**Y**	**N**	**Accutane**	**Y**	**N**
Laser, type____________	**Y**	**N**	**Oral Contraceptives**	**Y**	**N**
Botox	**Y**	**N**			
Fillers	**Y**	**N**			

Sun Exposure

Past: **Little** **OR** **Excessive**
Present: **Little** **OR** **Excessive**

What is your ethnicity? ____________________________________

Have you ever had Skin cancer? Y N

Any Known Autoimmune Diseases? Y N

Do you have Fibromyalgia? Y N

Personal Medical History

Please circle any of the below symptoms that are affecting your health

General: Fatigue, weight loss/gain, sleep problems, or night sweats

Skin: New or changing skin growths or rash

Head: Headaches or recent trauma

Eyes: Blurred or loss of vision, eye pain, discharge, contacts, dryness, LASIK, glaucoma

Nose: Frequent bloody nose, sinus pain, nasal drainage, congestion

Mouth: Tooth pain, oral sores, bleeding

Throat: Hoarse voice, voice changes, pain or difficulty swallowing, frequent soreness or swelling

Neck: Pain, stiffness, swelling

Mental Health: Feelings of nervousness/anxiety/panic, crying spells, depression, confusion, problems concentrating

Blood/Lymph: Anemia, bleeding tendency, easy bruising, swollen/painful lymph nodes

Other: ____

Please indicate which of the following have affected you:

	YES	NO
AIDS/HIV		
Alcoholism		
Anemia		
Anxiety		
Arthritis		
Asthma		
Bleeding Problem		
Cancer		
Dementia		
Depression		
Diabetes Mellitus		
Eye Problem/Glaucoma		
Heart Disease/Murmur		

Hemophilia	
High/Low Blood Pressure	
High Cholesterol	
Liver Disease/Jaundice	
Lung Disease	
Mental Illness	
Osteoporosis	
Parkinson's Disease	
Phlebitis/Blood Clot	
Seizures/Epilepsy	
Sickle Cell Disease	
Stroke	
Thyroid Disease	
Tuberculosis	

Allergies

- ☐ **None**
- ☐ **Medication Allergies** ____
- ☐ **Other** ____

Check one: ◻ Latex allergic ◻ Not latex allergic

Would you be able to lie on your back comfortably for 4 hours? ◻ No ◻ Yes

General/Social Information:

Any nicotine in the last 3 months? ◻ No ◻ Yes

◻ **Cigarettes** ◻ **Cigars** ◻ **Pipe** ◻ **Ecig** ◻ **Gum/patch**

◻ **Other** ___________________________

If yes, how much/how long? _____________________

Are you a former smoker? ◻ No ◻ Yes

If yes, when did you quit? ____________________

Do you drink alcohol? ◻ No ◻ Yes

If yes, how much and how often do you drink? ____________________________________

Exercise: how much/what kind? ____

Are you pregnant or nursing? ◻ No ◻ Yes

With whom do you live?

◻ I live alone ◻ I live with ____

Are you currently: (Please circle)

Single Married Partnered Widowed Divorced Separated

Emergency Contact?

___________________________________ __________________ ________________

(Name) (relationship) (phone #)

Please list all current medications

Prescription Drugs:

Name & Dose ____

Over the counter: (aspirin, Tylenol, antihistamines, herbals, vitamins, etc.)

Name & Dose____

Please list surgeries and hospitalizations:

	Year
______________________________	__________
______________________________	__________
______________________________	__________
______________________________	__________

ALL PROFESSIONAL SERVICES ARE CHARGED TO THE PATIENT; NO INSURANCE OR MEDICARE COVERAGES APPLY.I, THE UNDERSIGNED, DO HEREBY GIVE MY CONSENT DR. MICHAEL MORRISSETTE TO FURNISH TREATMENT CONSIDERED NECESSARY, AND PROPER IN DIAGNOSING AND/OR TREATING MY PHYSICAL AND COSMETIC CONDITION(S).

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Patient Signature Physician Signature

Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient's Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent.* The terms of our Notice may change. If we change our Notice, you may receive a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment, or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you agree to our use and disclosure of protected health information about you for treatment, payment, and health care operations. You have the right to revoke this Consent in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The Patient understands that:

- Protected health information may be disclosed or used for treatment, payment, or health care operations.
- The Practice has a Notice of Privacy Practices, and that the Patient has the opportunity to review this Notice.
- The Practice reserves the right to change the Notice of Privacy Practices.
- The Patient has the right to restrict the uses of the Patient's information, but the Practice does not have to agree to those restrictions.
- The Patient may revoke this Consent in writing at any time, and all future disclosures will then cease.
- The Practice may condition treatment upon the execution of this Consent.

Signature of Patient or Representative: ____

Relationship to Patient (if other than Patient): ____

Date: ____

* A detailed copy of our Notice of Privacy Practices is available at the Front Desk.

Cancellation Policy

For all laser, cosmetic appointments surgery appointments, we have a 24-hour notification policy. Requests for rescheduling or cancellations must be made with our office personnel 24 hours prior to the appointment date to avoid a cancellation fee.

Short Notice (Less Than 24 Hours) Rescheduling Request/Cancellation Fees Medical Appointments:

Laser Appointments $100.00
Cosmetic Appointments $100.00
Surgery Appointments $100.00

I have read this policy and understand that I will be charged for short-notice rescheduling requests or cancellations.

→ Signature: ____ Date: __________________