Rejuve Plastic Surgery
Kirit Bhatt, MD

Patient Information

Today's Date ____/____/____

Last Name	**First Name**	**Middle Initial**

SSN	Marital Status	Age	**Date of Birth**

Address		
City	State	Zip Code

Home Phone ( )	Mobile ( )	Work ( )

Email Address	Preferred phone
Height: Weight:	Emergency Contact & Phone #:
Occupation:	Employer:

How did you hear about us?

Medical Health History

Reason for visit:

Have you had plastic surgery before? ☐ yes ☐ no

If yes, type of surgery and when:

Previous surgeries:

Date	Type of surgery	Surgeon / Facility

Please list nutritional supplements and medications you are currently taking including hormone replacement therapy and birth control pills:

Allergies/sensitivities:

Latex	☐ yes	☐ no	
Lidocaine	☐ yes	☐ no	
Prescription drug	☐ yes	☐ no	Name of drug:
Anesthesia	☐ yes	☐ no	

Other allergies/sensitivities not listed:

How is your general health? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Do you exercise? ☐ yes ☐ no

☐ Smoker Date quit smoking: ☐ Never smoked

Other nicotine products used:

Do you drink alcohol? ☐ yes ☐ no If yes, type and how often:

Have you ever used Accutane? ☐ yes ☐ no If yes when?

Please check the following conditions you have currently or have experienced in the past:

☐ Abnormal Bleeding	☐ Headaches Heart	☐ Seizures
☐ Anemia	☐ Disease Hepatitis	☐ Stroke
☐ Asthma or COPD Cancer	☐ High Blood Pressure	☐ Thyroid disorder
☐ Diabetes	☐ High Cholesterol	

Other condition(s) not listed:

Skin Care History

Have you seen a Dermatologist in the past year? ☐ yes ☐ no

If yes, list Dermatologist's name and reason for visit:

Please list any skin treatment(s) you are currently having:

Please circle if you are presently using or have used in the past any of the following:

Hydrocortisone	Benzoyl Peroxide	Vitamin A	Resorcinol
Hydroquinone	Glycolic Acid (AHA)	Vitamin C	Salicylic Acid (BHA)
	Lactic Acid (AHA)		Sulfur

Please circle if you have had any of the following in the last 14 days:

Waxing	Facial Cosmetic Surgery	Permanent Cosmetics	Microdermabrasion
Laser Hair Removal	Botox Injections		Light Treatments
	Collagen Injections		Laser Resurfacing
	Dermal Fillers		Chemical Exfoliation (Peel)

Please circle if you are presently using or have used in the past any of the following **prescriptions:**

Tretinoin	Tazarotene (Tazorac)	Triluma
(Retin A, Retin -A Micro, Renova, Avita)	Isotretinoin (Accutane)	Metrogel
	Adepalene (Differin)	Azelaic Acid (Azelex, Finacea)

Any other topical antibiotic:

Please circle if you presently have or have had in the past any of the following**:**

Skin Cancer Dermatitis Keloid Scarring Herpes Simplex or Cold Sores	Acne Rosacea Broken Capillaries	Treatment Reaction Hypopigmentation (skin lightening) Hyperpigmentation (skin darkening)

Skin allergies/sensitivities:

Hydroquinone or skin bleaching agents ☐ yes ☐ no

Hydrocortisone ☐ yes ☐ no

Other skin allergies/sensitivities not listed:

Sun Protection

Do you use sunscreen? ☐ yes ☐ no

Do you sunbathe? ☐ yes ☐ no

Have you tanned in a tanning booth in the last 14 days? ☐ yes ☐ no

Have you had any direct sun exposure in the last 14 days? ☐ yes ☐ no

Have you recently used any self-tanning lotions or treatments? ☐ yes ☐ no

When exposed to the sun do you:

☐ Always burn, never tan	☐ Always burn, sometimes tan	☐ Sometimes burn, sometimes tan	☐ Always tan

Do you feel your skin is sensitive? ☐ yes ☐ no

Do you tend to scar easily or form raised scars (keloids)? ☐ yes ☐ no

Hair Removal/Laser Treatment History

Have you ever had laser hair removal? ☐ yes ☐ no

Please circle any of the following hair removal methods used in the past six weeks:

Shaving Waxing Electrolysis Plucking Tweezing Stringing Depilatories

Do you have Hyperpigmentation (darkening of the skin) or Hypopigmentation (lightening of the skin) or marks after physical trauma? ☐ yes ☐ no

If yes, please describe:

Please list any other necessary information your skin specialist should know before beginning your treatment:

I have acknowledged that all the information provided by me is true and correct to the best of my knowledge. I understand that some skin conditions may require more than one treatment as well as use of home care products as directed to achieve the results desired. Results cannot be guaranteed due to individual skin type(s) and condition(s).

I agree to inform the provider/staff of ANY changes pertaining to the above questionnaire prior to any future treatments. I certify that the preceding medical, personal and skin history statements are true and correct. I am aware that it is my responsibility to inform the esthetician, nurse or doctor of my current medical or health condition and to update this history now and in the future. A current medical history is essential for the caregiver to execute appropriate treatment procedures. I understand that payment is due at time of all services and products. There are **NO REFUNDS** on any cosmetic services.

_____ _____

Patient Signature **Date**