Lone Star Plastic Surgery

Patient Information

Today's Date ____/____/____ *General medical form

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

Marital Status	Age	**Date of Birth**
Address		
City	State	Zip Code
Home Phone ( )	Mobile ( )	Work ( )
Email Address	Preferred phone	

Would you like to receive information on promotions & events through email? ☐ yes ☐ no

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:

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

Are you presently under a physician's care? ☐ yes ☐ no If yes, why?

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

Other condition(s) not listed:

Allergies/sensitivities:

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

Other allergies/sensitivities not listed:

Previous surgeries:

Date	Type of surgery	Surgeon / Facility

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