THE NEW YORK AESTHETIC CONSULTANTS, LLP

260 East 66th Street New York, NY 10065 www.thenyac.com

PATIENT MEDICAL HISTORY

NAME_____ DATE_____

Please check and, if applicable, circle, any of the following conditions you currently have or have had in the past.

____Skin Cancer ____Other Cancer: (type:_____) ____Heart Disease (heart attack, angina, rheumatic fever, heart valve replacement, atrial fibrillation, mitral valve prolapse) ____High Blood Pressure ____Pacemaker ____Stroke or TIA (transient ischemic attack) ____Blood Clots ____Immune Deficiency ____Endocrine Disorder (diabetes, Cushings) ____Artificial Joints ____Blood/Lymph Gland Disorder (anemia, leukemia, low platelets, lymphoma, hemophilia, sickle cell) ____Taken Accutane (for acne treatments)	____Frequent Skin Infections ____Ear Disease (deafness, Meniere's, acoustic neuroma) ____Eye Disease (gluacoma, cataracts, blindness) ____Duodenal or Peptic Ulcer ____Intestinal Disease (irritable bowel, ulcerative colitis, Crohn's) ____Liver or Gall Bladder Disease ____Lung Disease (tuberculosis, asthma, emphysema, pleurisy) ____Kidney Disease ____Urinary or Bladder Problem/Infection ____Arthritis, Joint, Muscle or Bone Diseases (lupus, Raynauds, scleroderma) ____ Radiation Treatment ____ Chemotherapy ____Neurologic Disorder ____Emotional or Psychiatric History

•Have family members had: ____Melanoma ____Insulin-Treated Diabetes ____Excessive Scarring ____Cancer (type:_____)

•Do you: ____smoke (cigarettes, cigars, pipes) ____socially drink alcohol (____drinks/week) ____Use street drugs_____

•Please circle if you take any of the following on a regular basis:
Coumadin Aspirin Vitamin E Garlic Tablets Ginkgo Biloba Ginseng Ginger

•Do you have any allergies to any medications circle YES or NO if yes please indicate what medications and your reaction to them:

_____

_____

•Please circle if you have you ever had allergy or problem with any of the following and indicate your reaction if any allergies:
Local Anesthetic Epinephrine (Adrenaline) Latex Adhesives/Bandaids Antibiotic Ointment (eg. Neosporin, Bacitracin)

_____

•Have you or any family member had problems with anesthesia? no yes_____

•Have you ever had any problems with sulfites, commonly found in red wines and salad bars? no yes_____

•Please list any prior hospitalizations & surgeries:_____

_____

FOR WOMEN ONLY: Do antibiotics cause you to have yeast vaginitis?_____ Are you pregnant or nursing?_____ Have you missed your last menstrual period?_____ Are you planning a pregnancy?_____ Date of last mammogram_____
**Please inform us if any of these become true during the course of your treatment at subsequent visits.*

•If a spouse, parent, child, sibling or friend were to ask questions regarding your care, do you authorize The New York Aesthetic Consultantsr to discuss your care? If so, with whom? (please write names & relationship to you) _____

_____

•Do you allow us to leave medical information, such as laboratory results or answers to medical questions that were asked of us, on your voice mail or answering machine? yes no

•Is there anything else you think we should know about you in order to provide the best care possible?_____

MD INITIAL _____