PATIENT DEMOGRAPHICS

TODAY'S DATE_______________

PATIENT NAME____

BIRTHDATE____________________ AGE____SEX ____M____F

ADDRESS____

CITY________________________________STATE__________ZIP____________

HOME#(____)______________________ CELL#(____)_____________________

May Shu Cosmetic Surgery leave a message on your: Home Phone: __Y __N Cell: __Y __N Work: __Y __N

EMERGENCY CONTACT____

EMERGENCY CONTACT'S PHONE # _____________________________RELATIONSHIP TO YOU? _________________

DO YOU HAVE AN ADVANCED HEALTHCARE DIRECTIVE? IF SO, PLEASE SPECIFY _________________________________

____

WHERE DID YOU FIND US?____

**E-MAIL ____ REFERRED BY___________________________________

HAVE YOU EVER HAD A COSMETIC PROCEDURE BEFORE? ____

☐ Breast Augmentation	☐ Breast Implants	☐ Breast Lift	☐ Breast reduction
☐ Brow Lift	☐ Butt Lift	☐ Eyelid Rejuvenation	☐ Facelift
☐ Fat Transfer	☐ Injectables	☐ Hi Def Liposculpture	☐ Labia Rejuvenation
☐ Liposuction	☐ Laser Skin Care	☐ Neck Lift	☐ Cellulite Reduction
☐ Tummy Tuck	☐ Upper arm lift	☐ Vaginal Rejuvenation	☐ Chemical Peels
☐ Excessive Sweating	☐ Thigh Lift	☐ Liposonix	☐ Other

Shu Cosmetic Surgery SM

Name ___________________________________

Purpose of this visit (Location and procedure):

____

MEDICAL HISTORY

Your answers on this form will help us to get an accurate history of any medical conditions you may have. Please mark all that apply.

__Anemia	__Arthritis	__Asthma
__Bleeding Disorder	__Blood Clots	__Cancer
__Chronic Fatigue Syndrome	__Crohn's Disease	__Diabetes
__Emphysema/COPD	__Epilepsy, seizures	__Gout
__Heart Disease	__Hepatitis	__High Blood Pressure
__High Cholesterol	__HIV/AIDS	__Irritable Bowel/IBS
__Kidney Disease	__ Liver Disease	__Skin Problems/cancer
__Sleep Apnea	__Stroke	__Thyroid Disease
__Urinary Incontinence	__ Cold Sores/Herpes/Shingles	__Keloid Scars

Other____

If you checked any of the above, please explain

____

MEDICATIONS: List all medications, prescriptions, or non-prescriptions dosages and times taken per day.

Medications	Doses
______________________________	____
______________________________	____
______________________________	____
______________________________	____

ALLERGIES: Medications/Foods/Skin Allergies	What was your reaction?
____________________________	__________________________________
____________________________	__________________________________
____________________________	__________________________________
____________________________	__________________________________

SURGICAL/HOSPITALIZATION HISTORY:

Date of surgery or hospitalization

_______________________________	__________________________________
_______________________________	__________________________________
_______________________________	__________________________________

Name ____________________________________

ANESTHESIA REACTIONS: Describe/List any prior reactions to anesthesia in past

____

FAMILY MEDICAL HISTORY:

Marital Status (please circle): Single Married Divorced Widowed Separated

RELATIONSHIP	Living	Deceased	Age	Diseases
Father	____	____	____	____
Mother	____	____	____	____
Brother(s)	____	____	____	____
Sisters(s)	____	____	____	____
Son(s)	____	____	____	____
Daughter(s)	____	____	____	____

SOCIAL HISTORY: **Occupation**____

Cigarettes or tobacco ____Yes ____No How much/how often? _____________________________________

Alcohol ____Yes ____No How much/how often? _____________________________________

Drugs ____ Yes ____No How much/how often? _____________________________________

____

MEDSPA ONLY PATIENTS! Only for dermal filler, Botox, chemical peel, and laser treatment patients please answer:

1. What conditions would you like to improve? (circle all that apply)

Acne	Rosacea	Fine Lines and Wrinkles	Nail Fungus
Age, sun, brown spots	Flakiness	Skin Sagging	Cellulite
Acne Scarring or Scar	Stretch Marks	Broken Capillaries	Unwanted mole(s)
Skin Conditions: pore size/dryness/oiliness	Unwanted hair- area:	Spider Veins- location:	Other- Please specify

2. Have you been diagnosed with any skin conditions? No Yes If yes, please specify_________________
3. When was your last exposure to the sun (or a tanning booth)? ____________________________
4. Do you use chemical sun tanning lotions? Yes No
5. Are you planning an upcoming holiday in the sun? Yes No
6. Have you ever had skin resurfacing or rejuvenation or chemical peels? Yes No
   If yes, which one(s)? ____
7. Have you ever had treatments for pigmented lesions? Yes No
   Prior treatment (if any) ____
8. What skin care products do you use frequently? ____
9. Do you use any of the following products? (circle all that apply)

Retin A	Glycolic Acid
Hydroquinone	Salicylic Acid
Accutane	Other:

If you had any reaction to the above products, please explain:

____

Name ____________________________________

____

Signature of Patient or Guardian Date

NOTICE OF PRIVACY POLICY

Date______________________

I _______________________________, have reviewed the One Stop Medical Center/Shu Cosmetic Surgery Privacy Policy and Patients Rights. I agree with all the terms of this policy.

Please ask our front desk if you would like to REQUEST A COPY of the One Stop Medical Center/Shu Cosmetic Surgery Privacy Policy and Patients Rights. I agree with all the terms of this policy.