CHRISTINE FISHER|MD
BOARD CERTIFIED PLASTIC SURGEON

Aesthetic Medical History

Name: _____ Date of birth: _____
Address: _____
City: _____ State: _____ Zip: _____
Phone: _____ Email: _____
Occupation: _____ Referred by: _____

Reason for Consultation

- ☐ acne
- ☐ brown spots/sun damage
- ☐ double chin/improve jaw contour
- ☐ fine lines and wrinkles
- ☐ improve lip fullness
- ☐ redness/flushing
- ☐ skin laxity
- ☐ skin texture/scarring
- ☐ unwanted hair
- ☐ vaginal rejuvenation

What aesthetic treatments have you had before? _____
_____

Questions About Your Skin

1. How long have you been concerned about this problem? _____
2. When did you notice it? _____
3. Is it getting more pronounced? ☐ Yes ☐ No
4. Have you ever been treated for it before? ☐ Yes ☐ No
   a. When? _____
   b. Method used? _____
5. Are you currently taking medicine for it? ☐ Yes ☐ No
   a. If yes, what is it? _____
6. What topical skin medications or products do you currently use? ☐ Retin-A ☐ Retinol ☐ Hydroquinone/bleaching cream ☐ Other: _____
7. Have you ever had laser/IPL hair removal? ☐ Yes ☐ No
8. Have you used the following hair removal methods in the past six weeks? ☐ shaving ☐ waxing ☐ electrolysis ☐ plucking/tweezing ☐ threading ☐ depilatories
9. Have you ever had skin resurfacing or chemical peels? ☐ Yes ☐ No
10. Do you form thick or raised scars (keloids) when you heal? ☐ Yes ☐ No
11. Do you experience hyperpigmentation form burns, cuts, insect bites? ☐ Yes ☐ No

12. Have you ever had cold sores or fever blisters? ☐ Yes ☐ No

Skin Type

When exposed to the sun for about 1 hour with no protection you tend to:

- ☐ Always burns, never tans
- ☐ Always burns, sometimes tans
- ☐ Sometimes burns, always tans
- ☐ Rarely burn, always tans
- ☐ Brown, moderately pigmented skin
- ☐ Black, darkly pigmented skin

When were you last exposed to the sun or a tanning booth? _____

Do you use self-tanners? ☐ Yes ☐ No

Are you planning a vacation in the sun soon? ☐ Yes ☐ No

Skin Care

What does your current skin care routine include? What products do you use?

_____

_____

_____

Personal History

Do you smoke? ☐ Yes ☐ No If yes, how many packs per day? _____

Do you drink alcohol? ☐ Yes ☐ No Frequency/amount: _____

Do you wear contact lenses? ☐ Yes ☐ No

Medical History

1. Do you have any of the following?

- ☐ arthritis
- ☐ any active infection
- ☐ bleeding disorders
- ☐ bruising
- ☐ diabetes
- ☐ epilepsy or seizures
- ☐ heart disease
- ☐ hepatitis
- ☐ herpes simplex
- ☐ high blood pressure
- ☐ hormone imbalance
- ☐ HIV/Aids
- ☐ melasma
- ☐ MRSA history
- ☐ neuromuscular disease
- ☐ permanent makeup/tattoo
- ☐ sensitive teeth
- ☐ skin cancer or unusual moles
- ☐ skin injury
- ☐ vision deficits
- ☐ vitiligo

2. Are you pregnant or trying to become pregnant?
   ☐ Yes ☐ No
3. Do you have allergies to any of the following? (check any that apply)
   ☐ sulfa ☐ latex ☐ cow's milk ☐ anesthesia ☐ other: _____

4. Do you take any of the following?

☐ Accutane
☐ Antibiotics
☐ Anticoagulants
☐ Antidepressants
☐ Appetite suppressants
☐ Aspirin or Ibuprofen
☐ Cortisone/steroids
☐ Hormones or contraceptives
☐ Insulin
☐ Sedatives
☐ Thyroid medication

5. Are you taking herbal supplements or vitamins? ☐ Yes ☐ No If yes, please list:
   _____
6. Do you have a primary care physician?
   a. Name: _____
   b. Phone number: _____
7. Do you have a preferred pharmacy?
   a. Place: _____
   b. Phone number: _____

I have answered these questions to the best of my knowledge. I understand that it is my responsibility to inform my practitioner of my current health conditions while seeking treatment as a patient. I will update this information as it occurs.

Patient Signature: _____ Date: _____