HEARTLAND AESTHETICA
CURATED BEAUTY

Plastics Consultation Form

Patient Name: _____ **Date:** _____

Date of Birth: _____ **Age:** _____ **Gender:** _____ **Preferred Language:** _____

Address: _____

Phone Number: _____ **E-mail:** _____

Employer: _____ **Occupation:** _____

Primary Doctor: _____ **Referring Doctor:** _____

Preferred Pharmacy: _____

What is the main concern for your visit today?

_____

What areas of your body are affected?

_____

How long have you had this concern?

_____

Symptoms (circle all that apply): pain itch bleeding enlargement spreading burning redness embarrassment blistering other:

_____

What oral medications have you tried for this concern?

_____

What topical medications (prescription or OTC) have you tried?

_____

List any other treatments you have used (lasers, light options etc):

_____

Which of these products have been helpful?

_____

Past Surgical History

Select any of the following surgical procedures that you have had:

	Appendix: Appendectomy		Joint Replacement: Hip (Right/Left/Both)
	Bladder: Cystectomy		Kidney: Kidney Transplant
	Breast: Biopsy of Breast		Kidney: Kidney Stone Removal
	Breast: Mastectomy (Right/Left/Both		Kidney Biopsy
	Breast: Lumpectomy (Right/Left/Both)		Liver Transplant
	Breast: Biopsy of Breast		Liver: Hepatectomy
	Colon: Colostomy		Liver: Portosystemic Shunt Operation
	Colon: Colectomy		Ovaries: Tubal Ligation
	Gallbladder: Cholecystectomy		Ovaries: Oophorectomy
	Heart: Coronary Artery Bypass Graft (CABG)		Pancreas: Pancreatectomy
	Heart: Percutaneous Transluminal Coronary Angioplasty (PTCA)		Prostate: Biopsy of Prostate
	Heart: Tissue Graft Heart Valve Replacement		Prostate: Transurethral Prostatectomy (TURP)
	Heart: Mechanical Heart Valve Replacement		Proctectomy
	Heart Transplant		Rectum: Lower Anterior Resection
	Hysterectomy		Rectum: Abdominoperineal resection (APR)
	Skin: Skin Biopsy		Skin: Basal Cell Carcinoma
	Skin: Squamous Cell Carcinoma		Skin: Malignant Melanoma
	Testicle: Orchiectomy		

Other:

_____

Have you ever had any surgeries/procedures where bleeding complications occurred?

◯ YES ◯ NO Explain:_____

Do you wear Sunscreen? ◯ YES ◯ NO If yes, what SPF? _____

Do you tan in a tanning salon? ◯ YES ◯ NO

Do you have a family history of malignant melanoma? ◯ YES ◯ NO

If yes, which relative? _____

Do you have a family history of Basal Cell Carcinoma (BCC) or Squamous Cell Carcinoma (SCC)? ◯ YES ◯ NO

If yes, which relative? _____

Skin Disease History

Select any of the following that you have (mark all that apply):

	Acne		Eczema
	Actinic Keratosis		Asthma
	Dry Skin (Asteatosis Cutis)		Hay Fever/ Allergies
	Basal Cell Skin Cancer		Malignant Melanoma
	Poison Ivy		Flaking or Itchy Scalp
	Precancerous (Dysplastic)		Psoriasis
	Moles		Squamous Cell Skin Cancer
	Blisters Sunburns		Other:

Review of Systems

Are you currently or have you recently experienced any of the following (mark all that apply):

	Diarrhea		Vomiting
	Nausea		Fever or Chills
	Fatigue		Cough
	Night Sweats		Shortness of breath
	Unintentional weight loss		Weight gain
	Depression		Anxiety
	Pain/burning on urination		New onset of joint aches
	Numbness/weakness		

Alerts

Select any of the following that you have (mark all that apply):

	Allergy to Lidocaine		Allergy to Topical antibiotic Ointment
	Artificial Heart Valve		Artificial joint with the past 2 years
	Blood Thinners		Defibrillator
	Pacemaker		MRSA
	Premedication Prior to Procedures		Rapid Heartbeat with Epinephrine
	Pregnant		Planning Pregnancy
	Breastfeeding		Allergy to Adhesive

List any medications you are currently taking:

NAME	Dosage (mg/strength)	Times Per Day

List any Medication Allergies and the reaction you have:

_____

_____

_____

Social History

Smoking Status (Choose One)	Alcohol Intake (Choose One)
Never smoker	Never drinker
Current every day smoker	Less than 1 drink per day
Current social smoker	2-3 drinks per day
Cigar smoker	3 or more drinks per day
Former smoker (date quit) _____	Socially (weekends, events)

How many times in the past year have you had 5 (for men) or 4 (for women) or more drinks in a day? _____

Immunizations

For patients 65 and older, have you received the Pneumococcal (Pneumovax) vaccine?
○ YES ○ NO

For patients 50 and older, have you received the Shingles (Zostavax) vaccine?
○ YES ○ NO

For all patients, have you received the Influenza vaccine this flu season?

○ YES ○ NO