CHICAGO COSMETIC INSTITUTE

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AESTHETIC SURGERY
CERTIFIED BY THE AMERICAN BOARD OF PLASTIC SURGERY
MEMBER AMERICAN SOCIETY OF PLASTIC SURGEONS

Confidential Health Questionnaire for Facial Treatments

(Includes injections, lasers, surgical procedures)

Today's Date: _____

Name _____ Middle Name: _____ Last Name: _____

Age _____ Date of Birth _____ Gender: _____ Email: _____

Mailing address: _____ City: _____ State: _____ Zip Code: _____

Allowed forms of communication: (By allowing communication via telephone, I permit Chicago Cosmetic Institute to leave voicemails with persons other than myself)

Phone Number: _____ Other Phone Number: _____

Emergency Contact _____ Emergency Contact Phone Number: _____

Primary Care Physician _____ Phone Number: _____

Reason for visit _____

Which areas are of concern to you?

- ☐ Forehead
- ☐ Brow
- ☐ Eyelids
- ☐ Lips
- ☐ Chin
- ☐ Other _____
- ☐ Cheeks
- ☐ Neck
- ☐ Skin
- ☐ Nose
- ☐ Ears
- ☐ Loose skin
- ☐ Aging skin
- ☐ Scars

Past Facial Treatments

- ☐ Botox, Xemin, Dysport
- ☐ Injections or Fillers
- ☐ Laser treatments
- ☐ Facial surgery
- ☐ Accutane
- ☐ Other _____

MEDICAL INFORMATION

Allergies

- ☐ None
- ☐ Medications _____ Reaction _____
- ☐ Environmental _____ Reaction _____
- ☐ Latex Reaction _____

Medications (including dietary supplements, nonprescription and herbal products)

Past Medical History (list any past or current medical problems)

☐ Cold sores or herpes infections

Past Surgical History (list any past procedures & operations, including complications)

Social History

Current Occupation _____
Do you smoke or use tobacco? No Yes
Packs per day _____
Year started _____Year stopped _____
Do you drink alcohol? No Yes
Drinks per week _____
Do you use recreational drugs? No Yes

Marital Status: Married Single Widowed
Number of children _____
Will any dependents rely on you after surgery? _____
Are you planning on having more children? _____
Who will care for you after surgery? _____

Family Medical History (please explain if any of these conditions have affected a blood relative)

 Cancer Breast Disease Heart disease (heart attacks, heart bypass surgery) Abnormal reaction to anesthesia

Bleeding or Blood Clotting Disorders

Have you or any blood relative had problems with:

 Abnormal or excessive bleeding
 Abnormal or excessive blood clotting, also called Deep Venous Thrombosis (DVT) or Pulmonary Emboli (PE)

Do you have now, or have you been diagnosed as having (if yes, please explain)

Thyroid disease	Easy bruising	Stomach or intestinal bleeding	Hernia
Anemia	Asthma	Irregular or rapid heart beat	Immune disorders
Arthritis	Varicose veins	High blood pressure	Fainting or dizziness
Cancer or tumor	Seizures	Frequent gum or nose bleeds	Nervous breakdown
Diabetes mellitus	Palpitations	Angina or chest pain	Frequent heartburn or reflux
Heart attack	Hepatitis	Jaundice or liver disease	Mood disturbance
Heart failure	Kidney disease	Heart murmurs	Stomach or duodenal ulcer
AIDS or HIV positive	Stroke	Shortness of breath or wheezing	

How did you hear about our practice?

 Internet search Doctor Friend Other _____
 Television Magazine Web site _____

Who can we thank for this referral? _____

Completed by _____ **Signature** _____

Section below to be completed by physician

I have read & reviewed. Physician's Signature _____

Physical Exam: Height _____ Weight _____ lbs **Fitzpatrick**_____

Impression:

Recommendations:

Aesthetician	Nonablative	HSV prophylaxis
BTA	fCO2 Laser	
Filler	Surgical	

 Typical results reviewed Tobacco cessation Risks discussed Scars discussed Second visit offered Down time _____

Signature _____ **Date** _____

CHICAGO
COSMETIC INSTITUTE

Skin Typing Matrix

Name: _____

Please answer the following questions by circling the number which best describes you.
Your clinician will total your score during the consultation

My ethnic origin is closest to:	Very fair (Celtic and Scandinavian)	☐
	Fair-skinned Caucasian with light hair and light eyes	☐
	Pale-skinned Caucasian with dark hair and dark eyes	☐
	Olive-skinned (Mediterranean, some Asias, some Hispanic)	☐
	Dark-skinned (Middle Eastern, Hispanic, Asians, some African)	☐
	Very dark-skinned (African)	☐
My eye color is:	Light blue	0
	Blue / Green	1
	Green / Gray / Golden	2
	Hazel / Light Brown	3
	Brown	4
My natural hair color at 18 was:	Red	0
	Blonde	1
	Light Brown	2
	Dark Brown	3
	Black	4
The color of my skin that is not normal exposed to the sun is:	Pink to reddish	0
	Very Pale	1
	Pale with a beige tan	2
	Light Brown	3
	Medium to dark Brown	4
	Dark Brown – black	5
If I go out into the sun for an hour or so without sunscreen and have not been out in the sun for weeks my skin will:	Burn, blíster and peel	0
	Burn, then when the burn resolves there is Little or no color change	1
	Burn, then turns into a tan in a few days	2
	Gets pink, but then turns into a tan quickly	3
	Just tan	4
	Just gets darker	5
	My skin color is so dark I cannot tell	6
When was the last time the área to to be treated was exposed to natural sunlight, tanning booths or artificial tanning cream?	Longer tan one month ago	0
	Within the past month	1
	Within the past two weeks	2
	Within the past week	3

Total Score: ___

If your score is:	Your skin type is:
0 – 3	**1**
4 – 7	**2**
8 – 11	**3**
12 – 15	**4**
16 – 19	**5**
20 – 24	**6**

About you:

What is your hereditary background? (circle all that apply) Nordic/ Scandanavian/ Irish/ German/ English/ Asian/ Mediterranean/ Italian/ Hispanic/ Asian/ Native American/ Middle Eastern/ African American/ Other _____

If you sustain an injury to your skin such as a cut, burn, or bruise, how long does it take to fully resolve without any hyperpigmentation?

_____