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ELEVARE MD

aesthetics and skin care

Member
AMERICAN SOCIETY OF PLASTIC SURGEONS

American Board of Plastic Surgery
ABMS MOC®
Certification Matters

PERSONAL HISTORY QUESTIONNAIRE

Date

Name (Last, First) Age

Height Weight Sex M ☐ F ☐ Marital Status ☐ Single ☐ Married ☐ Widowed ☐ Divorced

Date of Last Physical Exam Physician

ALLERGIES (Please list any allergies you have to medications/foods.)

PAST MEDICAL HISTORY (Please list all medical problems you have currently or have had in the past and the year.)

PAST SURGICAL HISTORY (Please list all surgeries you have had.)

MEDICATIONS (Please list any medications you are taking including herbal therapies and topical creams.)

SOCIAL HISTORY

Do you smoke? YES NO How many packs per week?

Do you drink alcohol? YES NO How many drinks per week?

Do you exercise? YES NO What is your goal weight?

WOMEN ONLY

Is there a chance you may be pregnant? YES NO Are you breastfeeding? YES NO

How many children do you have?

Date of last mammogram: Normal or Abnormal, specify

MEDICAL SKINCARE ASSESSMENT

Have you ever been treated for a skin condition? YES NO If yes, what condition?

Have you ever had a cold sore? YES NO Do you use Retinol? YES NO

How do you tan? Burn Usually Burn Sometimes Burn Rarely Burn Never Burn

Have you ever had gold therapy? YES NO Do you have any tattoos? YES NO

Signature Date