PHYSICIAN'S CENTER for Beauty

Dr. Sean Maguire, Plastic Surgeon

Client Medical Inventory

Allergies

Drug Allergies (please list all): _____

_____

Sensitivity / Allergy to Latex: No / Yes

Any Reactions to an Anesthetic: No / Yes, if yes, describe: _____

_____

Current Medications

Name: _____ Dose: _____ Frequency: _____ Reason: _____

Name: _____ Dose: _____ Frequency: _____ Reason: _____

Name: _____ Dose: _____ Frequency: _____ Reason: _____

Name: _____ Dose: _____ Frequency: _____ Reason: _____

Name: _____ Dose: _____ Frequency: _____ Reason: _____

Name: _____ Dose: _____ Frequency: _____ Reason: _____

Name: _____ Dose: _____ Frequency: _____ Reason: _____

Name: _____ Dose: _____ Frequency: _____ Reason: _____

Additional (List): _____

Over the Counter Medications:

- Aspirin
- Ibuprofen

Do you take ANY herbal or natural supplements?

- No
- Yes, if yes, please describe: _____

Birth Control Pills:

- No
- Yes, if yes, name: _____

Are you pregnant?

- No
- Yes

Social History

Alcohol Intake:

- Never
- Rarely
- Socially
- Daily

Tobacco Use:

- No
- Yes, if yes, how many packs per day? _____ For How Long? ____ years

Current Medical Conditions

(Please Mark All Conditions Which Apply to You)

- Bleeding / Bruising / Clotting Disorders if yes, describe: _____
- Endocrine Disorders: Thyroid -- Over / Under Active
- Seizure Disorder / Heart Disease / Heart Pacemaker / Blood Vessel Disease
- High Blood Pressure
- Kidney Disease
- Arthritis
- Raynaud's Disease
- Autoimmune Disorders – Lupus / Rheumatoid Arthritis / Others
- Muscle Weakness / Disorders Myasthenia Gravis Diabetes Asthma
- Others (describe): _____

Past Medical History

Please list any surgical procedures in the past six months: _____
_____

Please list any prior cosmetic surgery: _____
_____

Primary Health Provider: _____

Pharmacy: _____ Phone / Email: _____

Skin / Aesthetic History

Current Skin Care Regimen:

- Wash Face with _____
- Moisturizer _____
- Any other products _____

Any Active Skin Infections / Conditions? No / Yes, if yes, describe: _____
_____

Current or Past Fever Blisters / Cold Sores / Herpes? No / Yes, if yes, describe: _____
_____

History of Excessive Scarring / Keloid Formation / Poor Wound Healing After Surgery?

- No
- Yes, if yes, describe: _____

Personal history of skin cancer?

- No
- Yes, if yes, describe: _____

Exposure to Retinoids:

- Prior Oral Intake of isotretinoin (Accutane)? No / Yes When last? _____
- Topical retinoids – tretinoin / adapalene / tazarotene?
    - No
    - Yes, if yes, how often, and when last? _____

Prior Microdermabrasion / Dermabrasion?

- No
- Yes, if yes, please describe: _____

Prior Chemical Peels?

- No
- Yes, if yes, please describe: _____

Prior Treatments for Wrinkles?

- Botox?
    - No
    - Yes, if yes, when last, and how often? _____
- Dermal Fillers?
    - No
    - Yes, if yes, please mark below
        - Restylane/Perlane? No / Yes if yes, describe: _____
        - Juvederm? No / Yes if yes, describe: _____
        - Bellafill? No / Yes if yes, describe: _____
        - Other? No / Yes if yes, describe: _____

Any problems with wrinkle treatments? No / Yes if yes, describe: _____

History of exposure to radiation treatments?

- No
- Yes, if yes, describe: _____

History of Skin Rash / Hives?

- No
- Yes, if yes, describe: _____

Have you any permanent make-up, implants, or tattoos?

- No
- Yes, if yes, describe: _____

Prior Injections with Gold?

- No
- Yes, if yes, please describe: _____

Have you recently used tanning creams?

- No
- Yes, if yes, describe: _____

How often do you sunbathe? (circle the best answer)

- Never
- Sometimes ≤10 days / year
- Regularly ≥11 + days / year

Have you visited a tanning bed / salon in last 90 days?

- No
- Yes, if yes, when last and how often? _____

Permission for Photography

I give permission for the Physician's Center for Beauty to take photographs of me before, during and after my treatments. As the condition creates a visual image, this image is important in the diagnosis and management of my concerns. These photographs will be an important part of my medical record. These photographs may be used (with identity protected) for research purposes, educational purposes and may be published in professional medical journals or books and for social media.

Signature: _____

Date: _____
(mm/dd/yyyy)