Patient ID_____

COSMETIC INJECTABLES CENTER

Patient Information and Consent for Cosmetic Services

Name_____Gender:_____ Age_____ Today's date:_____

Who may we thank for referring you to our office? _____
□ Self □ Referring medical professional □ Family □ Friend □ Yelp □ Google

Home Address:_____City:_____State:_____Zip_____

E-mail:_____ Date of Birth: _____ Drivers License:_____

Home #:_____ Cell #:_____ Work #: _____

Would you like a post-appointment follow up call? Yes / No

Which # may we leave a message re: instructions / appointment / health related info? Home / Work / Cell / All / None

Your Profession:_____ # of children:_____

Emergency Contact: _____
Name Relationship phone number(s)

Would you like to be added to our general office email list (no more than one email per month) Yes / No

If yes, which email address would you like us to use? _____

If we cannot reach you via phone numbers provided above, where can we leave messages with **personal/medical information**?

Email (for medical/personal contact only): _____ Phone:_____

Have you seen us on Google?	Yes / No
Have you used Google to leave reviews?	Yes / No
Have you seen us on Yelp?	Yes / No
Have you ever used Yelp to leave reviews?	Yes / No
Are you interested in skin care products or Latisse?	Yes / No

I understand that Dr. Sherly M. Soleiman is licensed and regulated by the Medical Board of California. (800) 633-2322. www.mbc.ca.gov.

Signature X_____ Date_____

Name (last, first)_____

Patient Medical Data

We need this information to give you the best care and treatment possible. All information is strictly confidential and is released only with your written consent.

Allergies: (including allergies to medication): □ No known allergies

_____

Herbs/Vitamins/Medications/Supplements:

List all **supplements/alternative** remedies (minerals, herbs, etc.), **prescriptions and over-the-counter medications:**

_____

Past Medical and Surgical History - Include hospitalizations:

List all hospitalizations and any surgeries/injuries and their approximate dates. (Continue on reverse if necessary):

_____

Which of following have you taken in last 5 days? (these may increase your chances of bleeding/bruising)

___Advil	___Aspirin	__ Vitamin E	__ Coumadin	__ Aleve
___Fish oils	___Naproxen	__ Ginko Biloba	__ Heparin	__ Plavix
___Alcohol ingestion	___Motrin	__ Ibuprofen	__Omega 3	__ Smoking

Have you ever had any of the following? **(PLEASE READ AND ANSWER ALL)**

Hepatitis A or B or C	yes/no	Muscle/Nerve diseases	yes/no	Currently Pregnant	yes/no
Cancer	yes/no	Muscular Dystrophy	yes/no	Currently Breast Feeding	yes/no
History of passing out	yes/no	Heart Murmur	yes/no	HIV	yes/no
Body Piercing	yes/no	Heart Ischemia/Stenosis	yes/no	Liver Disease	yes/no
Keloid Formation	yes/no	Heart Stent Surgery	yes/no	Coagulation Disorder	yes/no
Psoriasis	yes/no	Asthma	yes/no	Facial Surgeries	yes/no
Cold Sores	yes/no	Bleeding Disorders	yes/no	Vitamin K Deficiency	yes/no
Canker Sores	yes/no	Diabetes	yes/no	HIV	yes/no
Seizures	yes/no	Cirrhosis	yes/no	Organ transplant	yes/no
Autoimmune disease	yes/no	Kidney Failure	yes/no	Anti-rheumatic meds	yes/no
Stroke	yes/no	Tobacco Use	yes/no	Immune deficiency	yes/no
High Blood Pressure	yes/no	Chemotherapy	yes/no		

Other medical conditions not listed: _____

Do you have a special event coming up? _____ Do you have any Travel plans soon? _____

Previous Botox/Dysport/Filler/Cosmetic Procedure Experiences

Please describe what you have liked/disliked about your previous Cosmetic Injections:_____

_____

_____

I understand that the answers above are important for my safety and medical care. I certify that all of the above answers are true to the best of my knowledge. I acknowledge that I am financially responsible for all services rendered to me.

Name (print)_____**Signature**_____**Date**_____