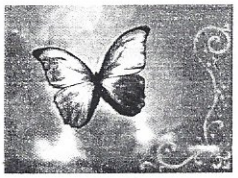
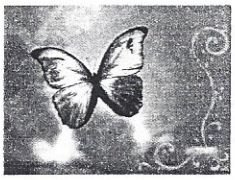


Deborah Nolan, ANP-BC, MSN



AESTHETIC PATIENT INFORMATION AND SELF-ASSESSMENT QUESTIONNAIRE

Name: _____

Address: _____

City: _____ State: _____ ZIP: _____

Home Phone: _____ Mobile Phone: _____ Work Phone: _____

Email Address: _____

Please indicate preferred method of contact: _____

1. What is the main reason you came in for this consultation?

_____

_____

2. What aesthetic treatments and procedures, if any, have you had in the past?

_____

_____

3. If you have previously had any aesthetic treatments or procedures, were you pleased with the outcome? Yes ☐ No ☐

If No, in what way were you dissatisfied?

_____

_____

4. Do you have any concerns about aesthetic treatments or procedures?

_____

_____

If yes, please identify your concerns: _____

_____

5. Please indicate your opinion on the following statement:
I would prefer correcting my facial wrinkles and lines with a product that does not contain animal-derived ingredients. Yes ☐ No ☐ Not sure, I would like to discuss ☐

The Medical Center of
Body Rejuvenation

AESTHETIC PRODUCTS, TREATMENTS AND PROCEDURES

Please let us know which of the following aesthetic products, treatments and procedures interest you. Please check all that apply.

___ Skin Rejuvenation

___ Topical Wrinkle Treatment

___ Dermal Fillers (Radiesse, Juvederm, Restylane, Perlane)

___ Botox

___ Dysport

___ Acne Treatment

___ Professional Skin-care Products (OBAGI)

___ Liver spot/Age spot correction

___ Sunscreen Advice

___ Chemical Peels

___ Leg Vein Correction

___ Lipo Selection/Body Contouring

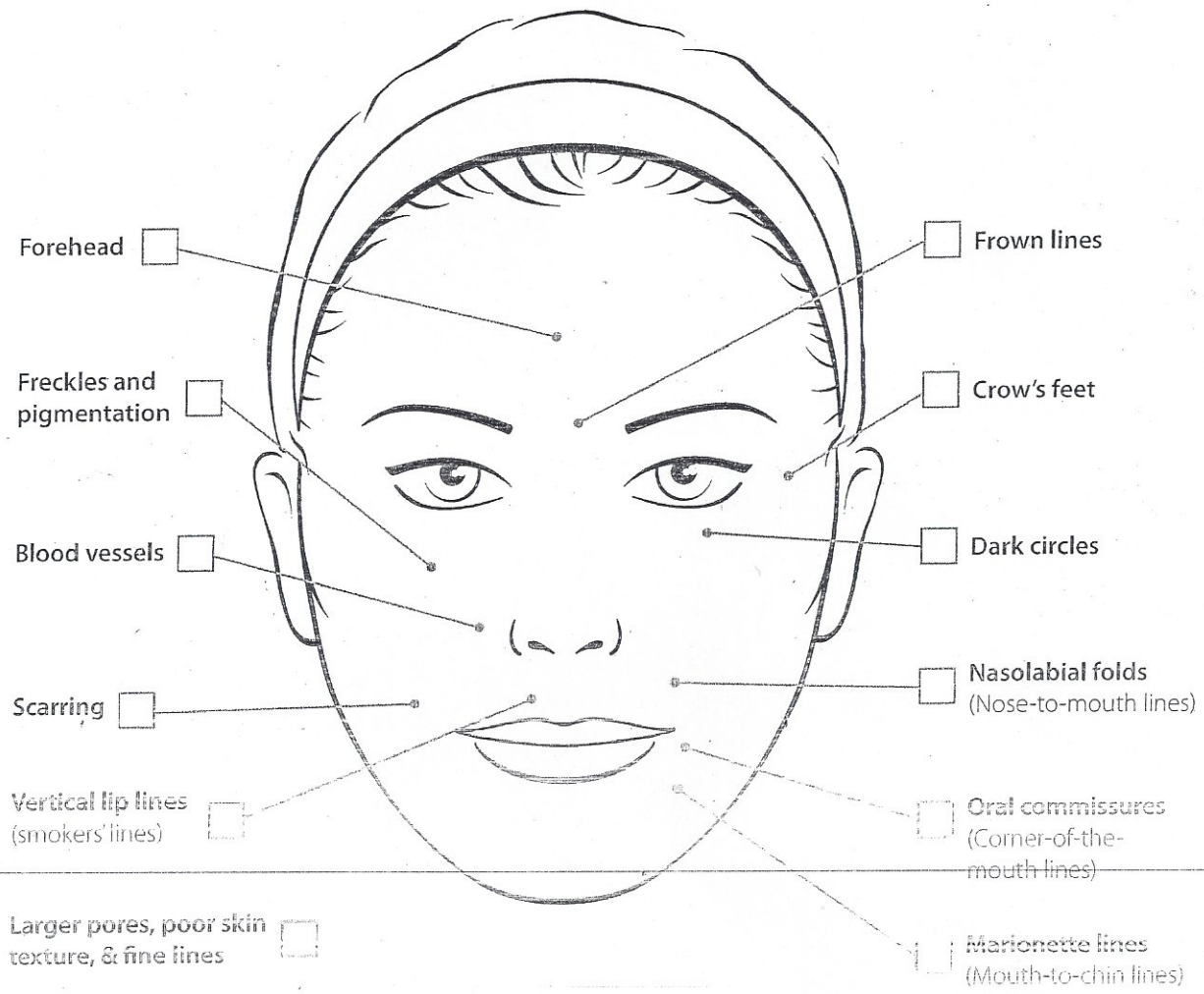
___ Medical Weight Loss

___ Other (please Specify): _____

_____

Facial Anatomic Representation

With respect to facial aesthetics, please highlight those areas of the face that bother or trouble you. In the boxes provided, please rate these areas on a scale of 1 to 5 (1 being least bothersome, 5 being most bothersome). Feel free to draw on the chart to identify any other facial concerns.



Thank you for completing this questionnaire.

Form courtesy of Medicis Aesthetics Inc.
AES 10-073 01/31/12

GREGORY NESTOR, M.D. *DEBORAH NOLAN, A.R.N.P.*

NAME_____ AGE_____ SEX_____ S M W D_____

ADDRESS_____ PHONE_____ DATE_____

NEXT OF KIN_____ ADDRESS_____

OCCUPATION_____ REFERRED BY_____

MEDICARE OR OTHER INSURANCE I.D.#_____ D.O.B._____

WHAT MEDICAL DOCTOR DID YOU LAST SEE?_____ WHEN_____

1. What childhood illnesses have you had? _____

2. Did you have any unusual or severe illnesses prior to age 18? _____

3. Give the year or your age if you have had any of the following operations:

Tonsillectomy_____	Hysterectomy_____	Ear Operation_____
Cataract Operation_____	Prostate Operation_____	Lung Operation_____
Gall Bladder Removal_____	Vein Operation_____	Hernia_____
Stomach Operation_____	Appendectomy_____	Artery Operation_____
C-Section_____	Eye Operation_____	Heart_____
Breast Surgery_____	Hemorrhoidectory_____	Others_____

4. If you have any of the following problems, please mark with an X:

Diabetes_____	High Blood Pressure_____	Prostate Problems_____
Anemia_____	Heart Trouble_____	Lung Trouble_____
Cancer_____	Kidney or Bladder Trouble_____	Stomach or Bowel
Arthritis_____	Female Problems_____	Trouble_____
Depression_____	Thyroid Problems_____	

5. If you have had any broken bones, whether right or left, and the year in which the injury occurred:_____

6. Give the years and reason if you have been hospitalized for anything besides injuries or operation:_____

7. Except as noted above, for what have you been treated by physicians during the past ten years other than common colds and the like: _____

8. What medicines do you now take and how often do you take them: _____

9. Have you ever had a blood transfusion? _____ When? _____ How Many? _____

10. List any medicines to which you are allergic: _____
Have you ever had asthma or hay fever? _____

(OVER)

11. Women Only: At what age did your periods commence? _____
At what age did they stop? _____
What if any trouble do you have with your periods? _____
_____
How many living children have you had? _____ How many still births? _____
How many miscarriages? _____

12. a. Occupation _____ Are you retired? _____
b. What is your spouse's age? _____
c. Do you consider him/her to be in good health? _____ If not, why not? _____
_____
d. In what year were you married? _____ How many beers, shots, cocktails and highballs do you consume in an average week? _____
e. How many pipes, cigars, or packs of cigarettes do you smoke per day, on the average? _____
_____
f. How many cups of coffee do you drink per day? _____ Tea _____
g. In what state were you born? _____ If foreign born, at what age did you come to this country? _____ In what state did you live most of your life? _____
h. Do you generally sleep well? _____
i. What are your principal hobbies or recreational activities? _____
j. If you were in the Armed Services, what branch and years? _____

13.

	LIVING			DECEASED		
	Age	State of Health	Chronic Diseases	Age at Death	Cause of Death	Other Illnesses
Father						
Mother						
Brothers						
Sisters						
Children						

Except as noted, have any close blood relatives had cancer? _____
_____
High Blood Pressure? _____
Diabetes? _____
Tuberculosis? _____
Any disease that run in the family? _____

HOSPITAL DATA:

Admission Date: _____ Admission Diagnosis: _____
Lab data: _____
_____
_____