GREENSBORO CENTER FOR FACIAL REJUVENATION

NAME:_________________________AGE:______DATE:______________

HOW DID YOU HEAR ABOUT US?_________________________________

1. What concerns brought you to the Center?_________________________________

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2. Circle the services that interest you.

Skin care	Botox	Fillers	Peels	Laser resurfacing
Nose	Ears	Eyelids	Forehead/Brow	Facelift

3. List any previous cosmetic treatments or procedures and the approximate year.

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4. Please list any other operations that you have had (such as tonsillectomy, appendectomy, hernia repair, gallbladder, etc.) and the approximate year.

Operation	Date
1.______________________________	____________________
2.______________________________	____________________
3.______________________________	____________________
4.______________________________	____________________

	Yes	No	How much/What kind/When quit?
5. Alcohol consumption?	☐	☐	______________________________
6. Have you ever smoked?	☐	☐	______________________________
7. Do you smoke now?	☐	☐	______________________________

Please turn over and complete reverse side.

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8. Have you or anyone in your immediate family had any of these problems?

	NO	YES	IF YES, EXPLAIN (yourself or relative e.g. mother, son, uncle)
Asthma/Allergies	☐	☐	____________________
Bleeding Disorders	☐	☐	____________________
Chest Pain/Heart Attack	☐	☐	____________________
Cold sores of lips	☐	☐	____________________
Emotional/Mental	☐	☐	____________________
High Blood Pressure	☐	☐	____________________
HIV/Hepatitis	☐	☐	____________________
Lung Disease	☐	☐	____________________
Liver Disease	☐	☐	____________________
Problems with Anesthesia	☐	☐	____________________
Sleep apnea	☐	☐	____________________
Skin conditions	☐	☐	____________________
Strokes	☐	☐	____________________
Sugar Diabetes	☐	☐	____________________

9. Please list any medications (including aspirin, blood thinners, vitamins, supplements, etc.)

Name of Medicine	How much each day?
1.____________________	_______________
2.____________________	_______________
3.____________________	_______________
4.____________________	_______________
5.____________________	_______________

10. Are you allergic to any medications (aspirin, penicillin, etc.)?

Name of Medicine	Reaction
1.____________________	_______________
2.____________________	_______________

Thank you very much.