



CALIFORNIA FACE & LASER INSTITUTE
Matthew Mingrone, M.D.

PATIENT INFORMATION FORM

APPOINTMENT DATE: _____

Name: _____
Last First Middle

Date of Birth: _____ Age: _____ Sex: _____

Please check next to the procedures or treatments that you are interested in-

- | | |
|---|--|
| <input type="checkbox"/> BOTOX Cosmetic | <input type="checkbox"/> Injectable Fillers (Juvederm/Restylane) |
| <input type="checkbox"/> Eyelid surgery | <input type="checkbox"/> Laser hair removal |
| <input type="checkbox"/> Facelift/Necklift/Minilift | <input type="checkbox"/> Spider veins / leg vein treatment |
| <input type="checkbox"/> Endoscopic browlift | <input type="checkbox"/> Photo facial |
| <input type="checkbox"/> Cheek lift | <input type="checkbox"/> Broken capillaries on the face |
| <input type="checkbox"/> Skin care | <input type="checkbox"/> Skin resurfacing/Active FX |
| <input type="checkbox"/> Scar revision | <input type="checkbox"/> Acne scar treatment |
| <input type="checkbox"/> Facial liposuction | <input type="checkbox"/> Chemical peel |
| <input type="checkbox"/> MicroLaserPeel/Microdermabrasion | <input type="checkbox"/> Ear correction |
| <input type="checkbox"/> Nasal surgery | |

Other interests not listed: _____

Which of the above have you already had performed? _____

MEDICAL HISTORY

Are you taking any drugs, medications or vitamins? YES NO If yes, list:
1. _____ 2. _____
3. _____ 4. _____

Are you allergic to any medications? YES NO If yes, list:
1. _____ 2. _____

Please list all previous surgeries (including cosmetic) and dates?
1. _____ 2. _____
3. _____ 4. _____

Have you ever received local anesthesia (Novocaine or Xylocaine) by a dentist or doctor?
 YES NO If bad reaction. describe:

Do you have now, or have ever had diseases or conditions of: (Please check YES or NO)

Lungs:	YES	NO	Gastrointestinal:	YES	NO
Asthma or Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	Ulcers	<input type="checkbox"/>	<input type="checkbox"/>
Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	Gastritis	<input type="checkbox"/>	<input type="checkbox"/>
Abnormal chest x-rays	<input type="checkbox"/>	<input type="checkbox"/>	Colitis	<input type="checkbox"/>	<input type="checkbox"/>
Shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>	Diverticulitis	<input type="checkbox"/>	<input type="checkbox"/>
Bronchitis/Pneumonia	<input type="checkbox"/>	<input type="checkbox"/>	Musculoskeletal/neurological:		
Cardiovascular:			Convulsions	<input type="checkbox"/>	<input type="checkbox"/>
High/low blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>
Blood clots in legs or lungs	<input type="checkbox"/>	<input type="checkbox"/>	Headaches	<input type="checkbox"/>	<input type="checkbox"/>
Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
History of leg swelling	<input type="checkbox"/>	<input type="checkbox"/>			
Abnormal electrocardiogram	<input type="checkbox"/>	<input type="checkbox"/>			
Chest pain	<input type="checkbox"/>	<input type="checkbox"/>			
PACEMAKER/Defibrillator	<input type="checkbox"/>	<input type="checkbox"/>			

Hematologic/metabolic:	YES	NO	Other systemic:	YES	NO
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Dry eyes	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding problems	<input type="checkbox"/>	<input type="checkbox"/>	Blurred vision	<input type="checkbox"/>	<input type="checkbox"/>
Blood transfusions	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>
Autoimmune disease	<input type="checkbox"/>	<input type="checkbox"/>	Corrective lenses	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Ear disease	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid disease	<input type="checkbox"/>	<input type="checkbox"/>	Nosebleeds	<input type="checkbox"/>	<input type="checkbox"/>
Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	Nasal/sinus disease	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding problems	<input type="checkbox"/>	<input type="checkbox"/>	Other: _____		

List any other diseases or conditions not covered above:

Social History:

Do you drink alcohol? YES NO If YES _____ drinks per week.
 Do you smoke? YES NO If YES, how much: _____
 Have you had or have you been exposed to HIV (AIDS)? YES NO
 (Women) Are you pregnant? YES NO Due Date: _____

Skin: One of the important parameters for the success of your treatment is the correct typing of your skin. Your doctor will consider your skin type when planning your treatment program for many aesthetic medical procedures. Skin type is often categorized according to the Fitzpatrick skin type scale which ranges from very fair (skin type I) to very dark (skin type VI). The two main factors that influence skin type and the treatment program devised by your doctor are genetic disposition and reaction to sun exposure and tanning beds.

Skin type is determined genetically and is one of the many aspects of your overall appearance, which also includes color of eyes, hair, etc. The way your skin reacts to sun exposure is another important factor in correctly assessing your skin type. Recent tanning (sun bathing, artificial tanning or tanning creams) have a major impact on the evaluation of your skin color.

Please take a few minutes and complete this questionnaire to help us determine your skin type and treat you the right way.

GENETIC DISPOSITION:

Score	0	1	2	3	4
What is the color of your eyes?	Light blue, Gray, Green	Blue, Gray or Green	Blue	Dark Brown	Brownish Black
What is the natural color of your hair?	Sandy Red	Blond	Chestnut/Dark Blond	Dark Brown	Black
What is the color of your skin (non-exposed areas)?	Reddish	Very pale	Pale with Beige tint	Light Brown	Dark Brown
Do you have freckles on unexposed areas?	Many	Several	Few	Incidental	None
	< Total score for Genetic Disposition				

REACTION TO SUN EXPOSURE:

Score	0	1	2	3	4
What happens when you stay too long in the sun?	Painful redness, blistering, peeling	Blistering followed by peeling	Burns sometimes followed by peeling	Rarely burns	Never had burns
To what degree do you turn brown?	Hardly or not at all	Light color tan	Reasonable tan	Tan very easy	Turn dark, brown quickly
Do you turn brown within several hours after sun exposure?	Never	Seldom	Sometimes	Often	Always
How does your face react to the sun?	Very sensitive	Sensitive	Normal	Very resistant	Never had a problem
	< Total score for Reaction to Sun Exposure				

TANNING HABITS:

Score	0	1	2	3	4
When did you last expose your body to sun (or artificial sunlamp/tanning cream)?	More than 3 months ago	2-3 months ago	1-2 months ago	Less than a month ago	Less than 2 weeks ago
Did you expose the area to be treated to the sun?	Never	Hardly ever	Sometimes	Often	Always
	< Total score for Tanning Habits				

	< Total score for Genetic Disposition
	< Total score for Reaction to Sun Exposure
	< Total score for Tanning Habits

	< SKIN TYPE SCORE
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FITZPATRICK SKIN TYPE

Skin Type Score	Fitzpatrick Skin Type
0-7	I
8-16	II
17-25	III
25-30	IV
Over 30	V-VI

The above information is strictly confidential

Completed by: Patient

Medical Assistant/RN _____
Initials

Signed by Patient Date

Reviewed by Date