NORTHERN VIRGINIA
SURGICAL SPECIALISTS

Patient Health Information Questionnaire

Name:_____ Age: _____ DOB:_____

Date:_____Address:_____

City:_____ State:_____Zip:_____

Phone Home:_____ Cell:_____Work:_____

Email:_____

Emergency Contact:_____ Phone:_____

Health History

Medication (Prescription & over the counter supplements):

_____
_____
_____
_____

Surgeries/Dates (Cosmetic & medical)

_____
_____
_____

Allergies (Latex, iodine, food etc.):_____
_____
_____
_____

Do you have an allergy to Lidocaine: Yes_____ No_____

Have a history of? (Check all that apply)

○ Heart Disease	○ Auto-Immune Disease
○ Cold Sores, Herpes	○ Seizures

○ Excessive Bleeding , Circulation problems	○ Migraines
○ Liver Disease	○ Fainting
○ Diabetes	○ Cancer
○ High Blood Pressure	○ Thyroid problems
○ Keloid Scarring	○ Other

Are you? Pregnant_____ Nursing_____ Menstrual problems_____

Do you? Smoke _____ Drink Alcohol _____ Amount per day _____

WHAT MEDICAL AESTHETICS PROCEDURES ARE YOU INTERESTED IN? (Check all that apply)

○ Botox
○ Dermal Fillers
○ Chemical Peels
○ Kybella

Have you ever had/Currently using:

○ Retin-A Renova	○ Prescription acne medication
○ Any retinoic acid	○ Birth Control Pills/Patch
○ Accutane	○ Steroids

Previous Cosmetic Facial Treatments:

○ Botox/Dysport	○ Microdermabrasion
○ Dermal Fillers	○ Chemical Peel
○ Laser Treatments	○ Permanent Make Up
○ Tattoo	○ Implants/Piercing

Tanning (Last 2 weeks): Yes Date:_____ No

What skin products are you currently using?

_____

_____

_____

The above information is true and accurate to the best of my knowledge
Patient Signature_____Date_____