BEVERLY MEDICAL CENTER FACIAL AND HAIR REJUVENATION QUESTION FORM

NAME:_____DATE:_____

Date of birth: _____ Age:_____

Have you have had facial treatments including but not limited to: Dermal Fillers YES ❑ NO ❑ Botox YES ❑ NO ❑ Microneedling YES ❑ NO ❑ Microdermabrasion YES ❑ NO ❑ Peels YES ❑ NO ❑

If yes, please write the type of treatment and the last time you had it performed.
_____

Have you had cosmetic surgery? YES ❑ NO ❑ If yes, please describe what type of procedures and when.
_____

What previous skin treatments have you had? (Such as IPL, laser, ultrasound any other treatment) YES ❑ NO ❑ If yes please describe which procedure and when:
_____

How do you want to improve your skin ? _____

_____

What skin care are you currently using? _____

_____

Do you have a tendency to keloid (make very thick raised scars)? YES ❑ NO ❑

Do you wear contact lenses? YES ❑ NO ❑

Do you work inside YES ❑NO ❑or outside YES ❑NO ❑?
Are your hobbies inside YES ❑NO ❑or outside YES ❑NO ❑?

Do you use chemical sun tanning products? YES ❑NO ❑___ If yes, when did you last use them._____

When was your last sun exposure? _____
Do you use tanning beds? YES ❑NO ❑
Are your hobbies done mostly inside YES ❑NO ❑ or outside YES ❑NO ❑?

When exposed to the sun without protection for about 1 hour, how does your skin react? Please check those which apply.
Burns always, never tans ☐ Burns always, sometimes tans ☐

Burns sometimes, sometimes tans ⚐▢ Tans always ⚐ ▢

Ethnic Background:

Caucasian ⚐▢ Hispanic ⚐ ▢ Asian ⚐▢ Mediterranean ⚐▢

Middle Eastern ⚐ ▢ African American ⚐ ▢

I bruise easily YES ❑ NO ❑ History of Eczema:YES ❑ NO ❑ History of Psoriasis YES ❑ NO ❑History of actinic or solar keratosis: YES ❑ NO ❑

I bruise easily YES ❑ NO ❑ I am using a retinoic acid treatment? YES ❑ NO ❑

I have used retinoid acid treatment? YES ❑ NO ❑ if yes, when?

_____

I am taking Accutane YES ❑ NO ❑ I have taken accutane in the past YES ❑ NO ❑ If yes, when? _____

I have a photosensitive disorder? (lupus, porphyria, sun rash, etc.) YES ❑ NO ❑

Cold sores (herpes virus) YES ❑ NO ❑ If yes, where exactly has this infection been located? _____

Sores in genital areas (herpes) YES ❑ NO ❑

If you have had hair loss, when did this start for the first time? _____

Has there been an acceleration of this loss and if so when?_____

Was there a precipitating event (pregnancy, stress etc), or exposure (medication etc)that brought about this hair loss? If no, leave blank if yes please explain: _____

_____

Have you had any other treatments for this hair loss including PRP, transplants or other? If so please explain: _____

_____

How did you hear about our services?

_____

Please check all treatments/services that interest you:

☐ Facial/neck/declote rejuvenation with micro needling with PRP combined with injections of PRP

☐ Hair rejuvenation and regrowth with PRP.

☐ Joint, tendon or trigger point injections PRP

I understand the information on this form is essential to determine my medical and or cosmetic needs and the provision of treatment. I understand that if any changes occur in my health I will report it to the practitioner as soon as possible. I have read and understand the above medical questionnaire. I acknowledge that all answers have been recorded truthfully and will not hold any staff member responsible for any errors or omissions that I have made in the completion of this form.

Patient Signature_____Date_____

BEVERLY MEDICAL CENTER: PRP and INTRAVENOUS NUTRITION GENERAL MEDICAL QUESTIONAIRE

_____ _____
NAME DATE

_____
Street name, number and apt number

_____
City, State, Zipcode

_____ _____ _____
CELL PHONE HOME PHONE EMAIL

Date of Birth _____/_____/_____ Age ____ Last Menstrual Period: _____

Family Physician_____ Family Physician Phone _____

ALLERGIES:	YES	NO		YES	NO
LATEX	❑	❑	IODINE	❑	❑
SULFA Drugs	❑	❑	Aloe	❑	❑
Hydroquinone	❑	❑	Bee stings	❑	❑
Daises	❑	❑	Herbals or other natural supplements	❑	❑

IF YES to any of these please write name, WHEN you last had the reaction and what was the reaction:

_____
_____

ALLERGY to ANY Medications: list medication and the reaction you get:

_____
_____

ALLERGY TO LIDOCAINE OR OTHER ANESTHETIC (numbing medicine such as when you get dental work injected or topical) YES ❑ NO ❑ If yes what was the reaction and when did it last occur:

_____
ALLERGY to foods, list foods and the reaction you get:

_____
_____

HAVE YOU EVER HAD A LIFE THREATENING REACTION TO ANYTHING? YES ❑ NO ❑ If yes what was the reaction and when did it last occur:

_____
_____

MEDICATIONS: PLEASE LIST ALL MEDICATIONS YOU ARE TAKING REGULARLY AND AS NEEDED —- THESE INCLUDE PRESCRIPTIONS AND OVER THE COUNTER MEDICATIONS (please include hormone therapy, prescription and over the counter medicated creams and injections):

_____

_____

Are you currently or have you in the past taking any anti-arhythmic medications (heart rhythm medication) ?

YES NOW ❑ YES PAST ❑ NO ❑

Do you have or have had a history of congestive heart failure? YES NOW ❑ YES PAST ❑ NO ❑

Do have or have had a history of any kind of heart disease? YES NOW ❑ YES PAST ❑ NO ❑

Are you currently taking any anti-anxiety medication? YES NOW ❑ YES PAST ❑ NO ❑

Do you take B12 injections? YES NOW ❑ YES PAST ❑ NO ❑

Do you have any of the following NOW or have you been treated for any of the following in the past 5 years :

Asthma YES Now ❑ YES Past ❑ NO ❑ **Epilepsy** YES Now ❑ YES Past ❑ NO ❑

Heart rhythm disturbance YES Now ❑ YES Past ❑ NO ❑ **Pacemaker** YES Now ❑ YES Past ❑ NO ❑

Internal defibrillator YES Now ❑ YES Past ❑ NO ❑ **High Blood pressure** YES Now ❑ YES Past ❑ NO ❑

Chronic Kidney Disease YES Now ❑ YES Past ❑ NO ❑ **Rheumatoid arthritis** YES Now ❑ YES Past ❑ NO ❑

Systemic or Skin Lupus YES Now ❑ YES Past ❑ NO ❑ **Thyroid imbalance** YES Now ❑ YES Past ❑ NO ❑

Migraines YES Now ❑ YES Past ❑ NO ❑ **Shingles** YES Now ❑ YES Past ❑ NO ❑

Diabetes non-insulin YES Now ❑ YES Past ❑ NO ❑ **Diabetes (take insulin)** YES Now ❑ YES Past ❑ NO ❑

Asthma YES Now ❑ YES Past ❑ NO ❑ **Other lung disease** YES Now ❑ YES Past ❑ NO ❑

Liver disease YES Now ❑ YES Past ❑ NO ❑

Osteoarthritis (Arthritis of any kind) YES Now ❑ YES Past ❑ NO ❑

Diseases of the nerves or muscles (ALS, Myasthenia Gravis, Lambert-Eaton etc) Yes ❑ No ❑ **If yes, please explain:** _____

_____

Autoimmune Disease (e.g. Rheumatoid Arthritis, Scleroderma, Lupus) Yes ❑ No ❑ ___ **If yes, please explain:** _____

Are you currently taking any blood thinners (for example: “Coumadin” (warfarin), “Pradaxa” (dabigatran), “Xarelto” (rivaroxaban) , “Plavix” (clopidogrel), “Eliquis” (apixaban) or any other blood thinner?

YES NOW ❑ YES PAST ❑ NO ❑

Have you used any NSAIDS in the last 48 hours these include but are not limited to, “Advil” (ibuprofen), “Clinoril” (sulindac), “Alleve”, “Anaprox” “Naprosyn” (naproxen), “Mobic” (meloxicam), “Voltaren” (diclofenac), “Indocin” (indomethacin), “Toradol” (ketorolac), “Feldene” (piroxicam) or any other: YES ❑ NO ❑

Cortisone injection in the area we will be treating within the last month or any other area: YES ❑ NO ❑

Oral cortisone (prednisone, methylprednisolone, hydrocortisone, “Pred pack”, “Medrol dospak or other corticosteriod) **within the last 2 weeks:** YES ❑ NO ❑

Do you smoke? yes ❑ no ❑ If yes how many per day? _____Do you drink alcohol? yes ❑no❑ If yes how many in a week total beverages? _____

Are you pregnant? yes ❑ no ❑ Breastfeeding? yes ❑ no ❑ Could you be pregnant? yes ❑ no ❑

Are you on Hormone therapy or Birth Control? yes ❑ no ❑ if yes what? _____

Do you wear contact lenses? yes ❑ no ❑

HAVE YOU EVER HAD PRP (platelet rich plasma injections) BEFORE? YES ❑ NO ❑

IF YES WHEN, WHERE AND FOR WHAT REASON?

_____

MEDICAL CONDITIONS Do you currently have or have you had any of the following - if yes please explain below:

HIV positive YES Now ❑ YES Past ❑ NO❑ **Critically Low Platelets**: YES Now ❑ YES Past ❑ NO ❑

Hepatitis B or C pos YES Now ❑ YES Past ❑ NO❑ **Blood or Bone Cancer** YES Now ❑ YES Past ❑ NO ❑

Diabetes Insulin dep YES Now ❑ YES Past ❑ NO ❑ **Diabetes oral meds only** YES Now ❑ YES Past ❑ NO❑

Scleroderma YES Now ❑ YES Past ❑ NO ❑ **Collagen Vascular Disease** YES Now ❑ YES Past ❑ No❑

Platelet Dysfunction Syndrome YES Now ❑ YES Past ❑ NO❑

Local or Chronic Infection at or near the site to be injected: YES Now ❑ YES Past ❑ NO❑

If yes is it bacterial ❑ or viral ❑(cold sore)

Any Scars less than 6 months old: Yes ❑ No ❑
If yes where and what for: _____

Do you currently have severe anemia with a Hemoglobin of less than 10 OR low platelets with a platelet count less than 105? Yes ❑ No ❑

Do you have a tendency to keloid (make very thick raised scars) ? Yes ❑ No ❑

Have you had Chemotherapy or immunosuppressive therapy within the last 4 months: Yes ❑ No ❑

Do you currently have Acute infection (SUCH AS: severe cold, bronchitis, pneumonia, urinary tract infection, herpes outbreak etc) ? Yes ❑ No ❑

Do you currently have Chronic Liver Disease: Yes ❑ No ❑

Do you have a history of congenital or idiopathic methemoglobinemia: Yes ❑ No ❑

I bruise easily YES Now ❑ YES Past ❑ NO ❑

I **am taking Accutane** YES Now ❑ YES Past ❑ NO ❑

I am using a retinoic acid treatment YES NOW ❑ YES PAST ❑ NO ❑

I have a photosensitive disorder? (lupus, porphyria, sun rash, etc.) YES NOW ❑ YES PAST ❑ NO ❑

Cold Sores (herpes virus) YES NOW ❑ YES PAST ❑ NO ❑

If yes where exactly has this infection been located? _____

_____

Sores in genital areas (herpes) YES NOW ❑ YES PAST ❑ NO ❑

LIST ALL PREVIOUS SURGERIES AND HOSPITALIZATIONS AND APPROXIMATELY WHEN THESE OCCURRED (OR WHAT AGE YOU WERE AT THE TIME)

_____

_____

_____

_____

How did you hear about our services? _____

Please check all treatments/services that interest you:

☐ Facial/neck/declote rejuvenation with micro needling with PRP combined with injections of PRP

☐ Joint, tendon or trigger point injections PRP

☐ Hair Rejuvination and Growth with PRP

☐ Vaginal and Orgasm rejuvenation with PRP

☐ Intravenous nutritional therapy

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