Sky Vein & Aesthetics

Aesthetic History

Danny L. Harrison, MD, FACS
1711 Destiny Lane, Suite 120, Bowling Green, KY 42104
(270) 846-1500

Patient Name: _____ _____ ___ Date of Birth: _____
Last First MI mm/dd/yyyy

Please take your time and fill out this extensive questionairre so that we may provide you with a personal and customized treatment plan. Thank you.

MY CONCERNS Mark ***X***

- ☐ Wrinkles
  - ☐ Forehead
  - ☐ Brow
  - ☐ Crows Feet
  - ☐ Perioral, Smokers Lines
  - ☐ Neck
  - ☐ Decollatage
- ☐ Sagging Skin
  - ☐ Hooded Eyebrows
  - ☐ Eyelid Droop
  - ☐ Jowling
  - ☐ Nasolabial Folds
  - ☐ Marionette Lines
- ☐ Neck Bands
- ☐ Aging Hands
- ☐ Sun (UV) Damage
- ☐ Facial Volume Loss
- ☐ Scars
- ☐ Acne
- ☐ Rosacea
- ☐ Hyperpigmentation
- ☐ Facial Veins
- ☐ Spider Veins
- ☐ Varicose Veins
- ☐ Stretch Marks

Mark ***X*** if **you have** or **TRUE**

- ☐ Facial Scars: Acne , Chicken Pox, ….
- ☐ Active Acne Problems

continued

- ☐ Dry Skin
- ☐ Oily Skin
- ☐ Rosacea
- ☐ Psoriasis (RC)
- ☐ Eczema, Atopic Dermatitis (NAD)
- ☐ Dermatitis
- ☐ Seborrhoeic Dermatitis
- ☐ Keloids
- ☐ Lupus
- ☐ Rheumatoid Arthritis
- ☐ Autoimmune Disease
- ☐ Herpes Simple (cold sores)
- ☐ Bruises easily
- ☐ Bleeding disorder (RC)
- ☐ Other Skin Problem
- ☐ Current Smoker
- ☐ Former Smoker: Quit _____
- ☐ Use Tanning Bed
- ☐ Pregnant
- ☐ Breast Feeding
- ☐ Seasonal Allergies

SKIN & SUN: Mark One

- ☐ I Always Burn / Never Tan
- ☐ II Burns easily / Tans poorly
- ☐ III Tan after initial burn
- ☐ IV Burns minimally, tans easily
- ☐ V Rarely burn, tans darkly easily
- ☐ VI Never burn

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TREATMENT HISTORY

☐ Xeomin, Botox, Dysport
_____
☐ Dermal Filler
_____
☐ Chemical Peel
_____
☐ Ultherapy
_____
☐ Cosmetic Microneedling
_____
☐ Medical Microneedling
_____
☐ PDO Thread Lift
_____
☐ LED Light Therapy
_____
☐ Radiofrequency
_____
☐ Laser
_____
☐ IPL
_____
☐ Facelift
_____
☐ Blepharoplasty
_____
☐ Implants
_____
☐ Cosmetic Tatoo
_____

YOUR SKIN CARE ROUTINE

☐ Use Sunscreen Daily
☐ Vitamin A / Retinol
☐ Hydroquinone
☐ Vutamin C
☐ Antioxidant
☐ Cleanser
☐ Exfoliator
☐ Toner
☐ Moisturizer
☐ Eye Cream
☐ Night Cream

Morning Routine:

_____
_____
_____
_____
_____
_____
_____

Evening Routine:

_____
_____
_____
_____
_____
_____
_____

TREATMENT INTERESTS

☐ Wrinkle Reduction

☐ Volume Replacement

☐ Skin Tone/ Texture

☐ Nonsurgical Facelift

☐ Improved Pigmentation

☐ Vein Treatments

_____
_____
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_____

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MEDICATIONS or Problem Treated

☐ Aspirin
☐ Blood Thinner
☐ Plavix
☐ Insulin
☐ Diabetic Pills
☐ High Blood Pressure
☐ Water Pill
☐ High Cholesterol
☐ Anxiety
☐ Depression
☐ Thyroid Disease
☐ Asthma Inhaler
☐ Asthma
☐ Arthritis
☐ Birth Control
☐ Hormone Replacement
☐ Testosterone
☐ Steroids ie. Prednisone
☐ Anabolic Steroids
☐ Antibiotic for Acne
☐ Antibiotic for Skin Infection
☐ Antibiotic Other
☐ Narcotic Pain Medications
☐ Ultram
☐ Cancer Treatment
☐ Minoxidel
☐ Immunosuppressants

MEDICAL CONDITIONS

☐ Asthma
☐ Diabetes
☐ Low Thyroid
☐ Hyperthyroid
☐ Rheumatoid Arthritis
☐ Osteoarthritis
☐ Migraines
☐ Bell's Palsy
☐ Epilepsy
☐ ALS
☐ Myasthenia Gravis
☐ Hepatitis
☐ Heart Disease
☐ COPD
☐ Multiple Sclerosis
☐ Melanoma
☐ Other Skin Cancer
☐ Other Cancer
☐ Peripheral Vascular Dis.
☐ Stroke, TIA
☐ Congenital Defect
☐ Serious Infection, MRSA
☐ HIV
☐ Pacemaker
☐ TB
☐ Poor Hearing
☐ Wear glasses, contacts
☐ Glaucoma

SUPPLEMENTS

☐ Vitamin A
☐ Vitamin C
☐ Fish Oil, Omega III
☐ Vitamin E
☐ Ginko Biloba
☐ Garlic
☐ Ginseng
☐ Dong Quai
☐ Vit B6 (Pyridoxine)
☐ St Johns Wort
☐ Feverfew

ALLERGIES

☐ Latex
☐ Lidocaine
☐ Penicillin
☐ Kefle
☐ Sulfa
☐ Aspirin
☐ Iodine
☐ Anaphylaxis
☐ Other

_____
_____
_____
_____

_____ ☐ Reviewed _____
Patient Signature Date Danny L Harrison, MD Date

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Patient Name: _____ _____ ___ Date of Birth: _____
Last First MI mm/dd/yyyy

_____ _____ _____ _____
Home Address City, State, and Zip Code

_____ _____
Cell Phone Email Address

☐ YES ☐ NO May we contact you by text message regarding appointments, etc.

☐ YES ☐ NO May we contact you by email message regarding appointments, etc.

How did you hear about us?

☐ Facebook ☐ Google ☐ VIP BG ☐ Cable ☐ MD
☐ Instagram ☐ Yelp ☐ Radio ☐ You Tube
☐ Daily News ☐ SoKy Happenings ☐ Friend: _____

Sex: ☐ Male ☐ Female

Pharmacy: _____

Street: _____ City: _____

Employer: _____ Occupation: _____ ☐ Retired

Who may we contact in case of emergency? _____ _____
Name Phone

Who is your primary physician? _____
Name

_____ I acknowledge the Practice has provided me a copy of its Notice of Privacy Practices, which provides a detailed description of the uses and disclosures allowed by this consent, as well as other rights I have regarding my protected health information.

_____
Patient Signature Date