JOSHUA E. GOLDBERG D.O.

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https://goldbergfacialplasticsurgery.com/

AESTHETIC INTAKE FORM

NAME_____ DOB_____ DATE_____

Please check what you would like to see improved:

___nasal appearance ___eyelid creases or bags ___facial or neck wrinkles or fine lines ___prominent ears ___reduction of brown spots or blemishes ___facial or neck scars ___facial or neck rejuvenation ___brow creases ___crow's feet ___higher cheek bones ___nasal folds ___mouth or Marionette lines ___fuller lips ___neck lines

MEDICAL HISTORY (please check all medical conditions past or present)

ARE YOUR PREGNANT?	yes	no
ARE YOU BREAST FEEDING?	yes	no
DO YOU FORM SCARS FROM CUTS OR BURNS?	yes	no
DO YOU HAVE DARKENING OF SKIN FROM CUTS OR BURNS?	yes	no
DO YOU HAVE LIGHTENING OF SKIN FROM CUTS OR BURNS?	yes	no
HAIR REMOVAL IN PAST 4 WEEKS?	yes	no
TANNING IN PAST 4 WEEKS?	yes	no
TANNING PRODUCTS IN PAST 2 WEEKS?	yes	no
KELOID SCARRING?	yes	no
COLD SORES?	yes	no
EASY BRUISING OR BLEEDING	yes	no
ACTIVE SKIN INFECTION	yes	no

NAME_____DOB_____DATE_____

MEDICAL HISTORY (cont.)

MOLES THAT HAVE RECENTLY CHANGED, ITCHED, OR BLED	yes	no
ASTHMA OR SEASONAL ALLERGIES?	yes	no
ECZEMA?	yes	no
THYROID PROBLEMS?	yes	no
POOR HEALING?	yes	no
DIABETES?	yes	no
HEART CONDITION or HIGH BLOOD PRESSURE?	yes	no
DO YOU HAVE A PACEMAKER?	yes	no
ANY NEUROLOGIC or MUSCLE CONDITIONS?	yes	no
SEIZURES?	yes	no
CANCER?	yes	no
HIV/AIDS?	yes	no
ARTHRITIS OR AUTOIMMUNE CONDITIONS?	yes	no
HEPATITIS?	yes	no
SHINGLES?	yes	no
HEADACHES OR MIGRAINE?	yes	no
HAVE YOU HAD SKIN CANCER?	yes	no
DO YOU HAVE PHOTOSENSITIVE SKIN?	yes	no
DO YOU SMOKE, VAPE, DRINK ALCOHOL?	yes	no
ARE YOU USING RETIN-A OR GLYCOLIC SKIN PRODUCTS?	yes	no

LIST ANY ILLNESSES, HEALTH, OR MEDICAL CONDITIONS:

_____

I CERTIFY THAT THE INFORMATION I HAVE GIVEN IS COMPLETE AND ACCURATE.

Client Signature: _____ Date: _____

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