HARTSOUGH DERMATOLOGY

Nicole A. Hartsough, M.D.
7402 East Riverside Boulevard
Loves Park, IL 61111

Phone (815) 226-9642 Fax (815) 226-9672

Medical History for Minimally Invasive Laser Procedure

Name: ____________________

Address: ____________________

Phone 1: ____________________ **Phone 2:** ____________________

Primary Care MD ____________________ **Office Phone:** ____________________

Female ☐ **Male** ☐ **Age:** ____________ **Last physical exam:** ____________________

Last EKG: ____________ **Last Chest X-ray** ____________ **Last blood work** ____________

Reason for consultation
- ☐ **ProLipo™**
- ☐ **Pro-V™**
- ☐ **Burn (Reconstruction)**
- ☐ **Others**

Cosmetic History

List all cosmetic surgeries and surgeons, along with the date(s) performed.

	Date	Procedure	Surgeon
1.			
2.			
3.			
4.			

List injectables such as Botox, Restylane, collagen, fat, or other.

	Date	Area	Any adverse reactions
1.			
2.			

Non-cosmetic surgeries

	Date	Procedure	Surgeon
1.			
2.			
3.			
4.			

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Personal history

1. Do you smoke? ☐ Yes ☐ No If yes, ______ packs per day, from what age________________
2. What is your daily consumption of alcohol? ______________________________
3. Do you wear contact lenses? ☐ Yes ☐ No
4. Do you have any of allergies? (check all that apply) ☐ medications ☐ latex ☐ food ☐ plants ☐ anesthesia ☐ other______________________________
5. Do you have any issues with bruising or bleeding? ☐ Yes ☐ No
6. Do you exercise regularly? ☐ Yes ☐ No
7. Have you ever had an issue with your nerves or muscles? (strokes, temporary paralysis, Bell's Palsey nerve injuries, etc. ☐ Yes ☐ No If yes, describe ______________________________
8. Do you need to take antibiotics before procedures such as dental? ☐ Yes ☐ No
9. Do you get fever blisters often? ☐ Yes ☐ No
10. Have you ever been treated for depression or other mental concerns? ☐ Yes ☐ No
11. Do any diseases run in your family? ☐ Yes ☐ No
12. Do you take any of the following?

☐ Antibiotics	☐ Anti-depressants
☐ Anti-coagulants	☐ Aspirin or Ibuprofen
☐ Blood pressure meds	☐ Hormone/contraceptives
☐ Cortisone or steroids	☐ Insulin
☐ NSAIDS	☐ Thyroid medication
☐ Sedatives	☐ Other___________

13. Are you taking herbal preparations or vitamins? (St. John's Wort, Vitamin E) ☐ Yes ☐ No

Medical History

1. Are you currently under the care of a physician? ☐ Yes ☐ No. If yes, for what:

____

2. Do you have any of the following?

☐ Arthritis	☐ Bleeding disorders	☐ Breathing issues
☐ Any active infection	☐ Bruising	☐ Back pain
☐ Blood clots	☐ Chest pain	☐ Epilepsy or seizures
☐ Cancer	☐ Diabetes	☐ Heart disease
☐ Hepatitis	☐ Other_____________	
☐ Herpes simplex		
☐ High blood pressure		
☐ HIV / Aids		
☐ Thyroid disease		

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For female patients

1. Are you pregnant or trying to become pregnant? ☐ Yes ☐ No
2. Are you breastfeeding? ☐ Yes ☐ No

I have answered the questions contained in this questionnaire to the best of my knowledge. I understand that it is my responsibility to inform my practitioner of my past and current health conditions as it pertains to the treatment I am seeking.

Signature: ____ **Date:** _____________