COSMETIC PATIENT FORM

deNovo
+ HEALTH +

Name: ______________________ **Date of birth:** ______________________

Personal Data					
Address:	City:	State:	Zip Code:	Gender:	Age:
Name Of Employer:				Phone Numbers Cell: Home: Work:	
Work Address:	City:	State:	Zip Code:		
Email:					
How did you hear about deNovo Health?			May leave private medical information on email?	Yes	No

Social History					
Marital Status	Single	Married	Divorced	Widowed	In a Relationship
Living Arrangements		Rent	Own	Other	# of people living at home:
Highest Education:					# of pets at home:
Occupation:			Hours per week:		Shift worked: AM PM

Health Goals - Please list what health or service goals you would like to discuss with your provider and why

Goal	Reason

Health Habits							
Sleep	Hours of sleep per night:		# of naps per week:		Do you snore?	Yes	No
	Trouble Sleeping:					Yes	No
Eating	Servings per day of fruit:			Servings per day of vegetables:			
	Servings per day of dairy:			Servings per day of protein:			
	Servings per day of grains:			Servings per day of water:			
	Salt intake	Low	Medium	High	# of meals per day:		
	Fat Intake	Low	Medium	High	# of snacks per day:		
	Sugar Intake	Low	Medium	High	Are you dieting?	Yes	No
	Do you follow a particular diet? If so please describe:						
Caffeine	Amount per day:			Coffee	Tea	Cola	Other
Exercise	Hours of exercise per week:						
	Type of Exercise:						
Tobacco ☐ Never Used	Former Use	Type:		Amount per day:		# of years used:	
	Current Use	Type:		Amount per day:		# of years used:	

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Skin

General Disposition	Circle one item on each line	0	1	2	3	4
	Eye Color	Gray, Hazel	Light Blue, Green	Blue	Dark Brown	Brown-Black
	Hair Color	Red	Blonde	Chestnut, Dark Blonde	Dark Brown	Black
	Unexposed Skin	Reddish	Very Pale	Pale Beige tint	Light Brown	Dark Brown
	Freckles	Many	Several	Few	Incidental	None
	SUB-TOTAL (staff only)					

Reaction to Sun Exposure	Circle one item on each line	0	1	2	3	4
	What happens when you stay in the sun for too long?	Red, blistering, peeling	Blister then peel	Burn sometimes then peel	Rarely burn	Never had a burn
	To what degree do you turn brown?	Hardly, or not at all	Light color tan	Reasonably tan	Tans easily	Turn dark quickly
	Do you turn brown within several hours after sun exposure?	Never	Seldom	Sometimes	Often	Always
	Your faces reaction to the sun?	Very sensitive	Sensitive	Normal	Very resistant	Never a problem
	SUB-TOTAL (staff only)					

Tanning Habits	Circle one item on each line	0	1	2	3	4
	Last exposure to sun, sunlamps or tanning bed	More than 3 months ago	2 - 3 months ago	1 - 2 months ago	Less than a month ago	2 weeks or less
	Do you expose the areas to be treated?	Never	Hardly Ever	Sometimes	Often	Always
	SUB-TOTAL (staff only)					

Fitzpatrick Skin Type Score OFFICE USE	Score	Skin Type	Score	Skin Type	Table Score	Visual Score
	0-7	I	26-30	IV	OFFICE USE	OFFICE USE
	8-16	II	Over 30	V-VI		
	17-25	III				

Skin Condition					
	How does your face feel upon awakening?		Oily	Dry	Normal
	After cleansing in the morning how soon do you notice an oily shine?				
	Before noon	Noon - 3 pm	After 3 pm	Not at All	
	Do you experience acne?			Yes	No
	Is your acne worse prior to your period?			Yes	No
	Do you ever experience flakiness of your skin?			Yes	No

Botox & Fillers ☐ No History				
	Have you ever had botox?		Yes	No
	How long did it last?	Were you satisfied?	Yes	No
	Have you ever had fillers?	If so what type:	Yes	No
	How long did it last?	Were you satisfied?	Yes	No

Cosmetic Surgery ☐ No History	Year	Name of Surgery

Skin Cancer ☐ No History			
	Have you ever had any moles or skin removed?	Yes	No
	Have you ever had skin cancer?	Yes	No
	Location(s):		

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Prevention & Screening				
Vision & Hearing	Last eye exam?			
Health Screening	When was your last skin exam?	Was it normal?	Yes	No
	When was your last dermatology exam?	Was it full body?	Yes	No
	Results from dermatology exam:			
	Females			
	When was your last gyn exam?	Was it normal?	Yes	No
	When was your last mammogram?	Was it normal?	Yes	No
	Males			
	When was your last testicular exam?	Was it normal?	Yes	No
	When was your last prostate exam?	Was it normal?	Yes	No

Life Satisfaction							
	DIRECTIONS: Below are five statements with which you may agree or disagree. Using the 1-7 scale below, indicate your agreement with each item by placing the appropriate number in the line preceding that item. Please be open and honest in your response.						
	1 Strongly Disagree	2 Disagree	3 Slightly Disagree	4 Neither Agree Or Disagree	5 Slightly Agree	6 Agree	7 Strongly Agree
	The conditions of my life are excellent.						
	I am satisfied with life.						
	So far I have gotten the important things I want in life.						
	If I could live my life over, I would change almost nothing.						

Mental Health			
	Is stress a major problem for you?	Yes	No
	Do you feel depressed?	Yes	No
	Do you panic when you get stressed?	Yes	No
	Do you cry frequently?	Yes	No
	Have you ever attempted suicide?	Yes	No
	Have you ever thought about hurting yourself?	Yes	No
	Have you ever been to a counselor?	Yes	No

Past Medical History			
Medical Surgeries	Year	Reason	Place
Hospitalizations	Year	Reason	Hospital
Blood Transfusion	Year	Reason	Hospital

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Past Medical History (continued)

	Year Diagnosed	Disease Name	Currently Under Treatment? (Doctor 's Name)	Yes
Disease Processes				

Allergies	Please include **ALL MEDICATIONS**, foods, environmental and other substances	

Current Medication

Name	Dose	Route	Frequency	Reason Prescribed

The answers I have provided are true and accurate to my knowledge.

NAME PRINTED ______________________ SIGNATURE ______________________ DATE ______________

Photography Consent

Pictures will be obtained for medical records. If you approve & provided that your name is not revealed & all identifying marks are cropped or removed, these photographs may be used for in-house medical, educational, scientific or advertising purposes.

PATIENT SIGNATURE ______________________ DATE ______________

STAFF USE ONLY

CC / HPI	PE / DX	RTP
		VS
		HSCR