Patient's Name:_________________________________ **Account#:** _________________ **Date:** ________________

Please indicate which of the following concerns you would like to discuss with Dr. Kaplan:
Please write 1, 2, 3, etc. to describe which area of improvement is your first, second, third, etc. priority

☐ Heavy Eyelids ☐ Bags Under The Eyes ☐ Sagging Brow ☐ Neck/Chin ☐ Jowls ☐ Nose ☐ Protruding Ears
☐ Mouth ☐ Wrinkles ☐ Skin texture ☐ Brown Age Spots ☐ Other___________________________________

Briefly describe what you would like Dr. Kaplan to help you improve.____

____

____

• PATIENT MEDICAL HISTORY •

• GENERAL HEALTH •

MEDICAL HISTORY: Check each medical condition listed below which you currently have or had in the past.
☐High Blood Pressure ☐Diabetes ☐Skin Cancer ☐Cancer _____________ ☐Respiratory Problems ☐Heart Disease
☐Tuberculosis ☐Hepatitis or Other Viral Disease ☐Auto Immune Disease ☐ Other__________________________

Are you pregnant? ☐Y ☐N **Are you prone to cold sores?** ☐Y ☐N **Have you developed keloid or hypertrophic scars?** ☐Y ☐N

When was your last general physical? Month / Year _____/_______. **Name of Physician**________________________

Past Hospitalizations or Surgeries (include plastic surgery):
What? Why? Where? When?

____

____

____

Have you had ANY problems with anesthesia (medical or dental procedures)? List Details.________________________

____

Please list any other serious illnesses or medical conditions that you currently have or had in the past.

____

____

Have you seen a cardiologist? ☐Y ☐N Physician's Name:__________________________ Date of last EKG:___________

BLEEDING HISTORY: Do you clot normally? ☐Y ☐ N Please explain if there is a family history of bleeding disorder?

____

FAMILY HISTORY: ☐Diabetes ☐High Blood Pressure ☐Cancer ☐Heart Disease ☐Other________________________

ALLERGIES: Please list EACH drug that you are allergic to: ____

____

I have sensitivities/allergies to the following: ☐Latex: ☐ Aspirin ☐Lidocaine ☐Alpha Hydroxy Acids ☐Aloe Vera
☐Vitamin C ☐Copper ☐other____

List **any other** allergies ____

SMOKING HISTORY: Are you a smoker? ☐Y ☐N If yes,______# /day Ex-smoker? ☐Y ☐N If yes, year quit______

ALCOHOL CONSUMPTION: How often do you drink?__________________ How much do you drink?____________________

• MEDICATIONS •

Please check all medications you are currently taking or have taken in the last 6 months. Also note the last time each was taken.

☐Aspirin?_______ ☐ Coumadin?__________ ☐ Ibuprofen/Advil_________ ☐Anti-Inflammatory/Arthritis drugs?_________________
☐Blood Pressure drugs?_________ ☐ Other Drugs____
☐Vitamin E____________(#I.U.'s_______/day) ☐Gingko ____________ ☐ Multi-Vitamins_____________ ☐ Diet Pills ___________

☐I am ☐ I am not on the drug **Accutane.** If you have taken the drug **Accutane**, when did you stop taking it? ____MO._____YR.