Consultation Form

Patient Name: _____ **Date :** _____

D.O.B: _____ **Phone Number:** _____**Cell Number:** _____

Email Address: _____

Mailing Address: _____ **City:**_____ **Zip**:_____

Questions

- How did you hear about Dr Florea? _____
- What areas would you like to enhance/address? _____
- When did you first begin noticing the signs of aging?_____
- What preventative methods have you incorporated Since noticing these changes? _____
- Is this your first time visiting a cosmetic office? _____
- Were you nervous about coming in for today's appointment? Yes / No
  If Yes, why? _____
- Do you Work outside of the Home? If so what is your occupation? _____
- Have you thought about when you would like to have the Rejuvenation procedure?_____
- Do you have any upcoming special events? If so, what types? _____
- Did you tell anyone you were coming in today? If so, who? _____
- Will they be excited for you? If not how will you handle that? _____
- What do you foresee as the biggest benefit/change from having the procedure? _____

A little bit more about you

What medications or supplements (prescribed and non-prescribed) are you taking?

_____

_____

Please list any medications that you are allergic to and describe the reaction, if any.

_____

Family Physician: _____ Phone Number: _____
Date if last exam: _____/_____/_____
Cardiologist's Phone number (if applicable):_____
May we contact your physician(s) in order to obtain a medical clearance if necessary? ☐Yes ☐No
Did anyone accompany you to the consultation today? ☐Yes ☐No
If so, who? _____

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* To protect the privacy of our staff and patients, No recording devices of any kind are allowed to be brought in during your consultation, visits or procedure. For your security and to insure you are receiving outstanding care, you may be inadvertently recorded by our security cameras during your visit.

PATIENT MEDICAL HISTORY

Patient Name: _____ D.O.B: _____

I. Medical Exclusions

1. Have you had a heart attack within the past 12 months?	☐Yes	☐No
2. Are you currently pregnant?	☐Yes	☐No
3. Are you currently undergoing radiation therapy or chemotherapy for cancer?	☐Yes	☐No
4. Have you had a history of a connective tissue disorder (e.g., Ehlers Danlos Syndrome)?	☐Yes	☐No
5. Do you have severe emphysema or another condition that is oxygen-dependent (e.g., COPD)	☐Yes	☐No

II. Medical History

Please respond to the following conditions:

1. Have you had surgery in the facial area within the previous 9 months?	☐Yes	☐No
2. Limited neck mobility?	☐Yes	☐No
3. Asthma that is inhaler-dependent or other lung problems?	☐Yes	☐No
4. Bleeding disorder?	☐Yes	☐No
5. Abnormal scarring?	☐Yes	☐No
6. Reaction to lidocaine or latex?	☐Yes	☐No
7. Serve dry eyes?	☐Yes	☐No
8. Are you currently taking Coumadin, Plavix or Aspirin on Dr.'s orders?	☐Yes	☐No
9. HIV/AIDS?	☐Yes	☐No
10. Kidney insufficiency?	☐Yes	☐No
11. Liver insufficiency or cirrhosis?	☐Yes	☐No
12. Phlebitis or blood clots?	☐Yes	☐No
13. Diabetes that is not controlled?	☐Yes	☐No
14. Angioplasty with stent placement?	☐Yes	☐No
15. Heart disease or heart problems?	☐Yes	☐No
16. Heart catheterization/stress test?	☐Yes	☐No
Date: _____	☐Normal	☐Abnormal
17. High blood pressure?	☐Yes	☐No
☐High ☐Low ☐Normal 120/80		
18. History of aortic aneurysm?	☐Yes	☐No
19. History of heart attack?	☐Yes	☐No
20. History of stroke?	☐Yes	☐No
21. Do you have a pacemaker?	☐Yes	☐No
22. Angina or chest pain w/ exercise?	☐Yes	☐No
23. Are you a current smoker?	☐Yes	☐No
24. History of seizure disorder?	☐Yes	☐No

III. Anything else we should know?

Please list anything your doctor should know about your health, including and drug allergies, previous surgeries, other medical problems or special concerns:

I certify that I have listed all of my current medications, allergies, hospitalizations, medical conditions and previous surgeries to the best of my knowledge and ability.

_____ _____

Patient Signature Date