

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? _____

Andrew S Florea, MD
1174 Nevada St. Suite 100 Redlands CA 92374 Phone 909-335-3000

* 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? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 2. Are you currently pregnant? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 3. Are you currently undergoing radiation therapy or chemotherapy for cancer? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 4. Have you had a history of a connective tissue disorder (e.g., Ehlers Danlos Syndrome)? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 5. Do you have severe emphysema or another condition that is oxygen-dependent (e.g., COPD) | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

II. Medical History

Please respond to the following conditions:

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