Cavalon Aesthetics

COSMETIC SURGERY AND SKIN REJUVENATION

Patient Health Questionnaire

Today's Date: ___________
Name: ___________________________ DOB: _____________________________
Sex: F / M Age: _________ Email: _____________________________
Mailing Address: ____
Home Phone: ______________________ Cell Phone: _________________________ Work Phone: _________________________
Emergency Contact Name and Relationship: ____________________________________
Emergency Contact Phone Number: _____________________________________
Primary Care Physician: _____________________________________

Referred by:
- ☐ Patient of Dr. Henderson
- ☐ Friend or Acquaintance
- ☐ My Doctor
- ☐ Attended Educational Program
- ☐ Web Site
- ☐ Advertisement
- ☐ Other

Name/Source: ____

May we send a thank you to the person listed above?
Yes or No

Health History

- ☐ Do you smoke?
- ☐ Drink Alcohol?
- ☐ Diabetes?
- ☐ Asthma/emphysema?
- ☐ Shortness of breath?
- ☐ High blood pressure?
- ☐ Heart disease?
- ☐ History of heart attack?
- ☐ Heart valve disease (prolapse)?
- ☐ Stroke?
- ☐ Chest Pain?
- ☐ Seizure/epilepsy?
- ☐ Easy Bruising/bleeding?
- ☐ HIV?
- ☐ Hepatitis/Liver disease?
- ☐ Anemia?
- ☐ Thyroid Disease?
- ☐ Tuberculosis?
- ☐ Other lung issue?
- ☐ Rheumatic fever?
- ☐ Cold sores/fever blisters?
- ☐ Wear eyeglasses?
- ☐ Wear contact lenses?
- ☐ Skin lesions?
- ☐ Recurrent eyelid swelling?
- ☐ Cataracts?
- ☐ Dry eyes?
- ☐ Hearing aid(s)?
- ☐ Dentures?
- ☐ History of cancer?
- ☐ Poor scarring?
- ☐ Keloids?
- ☐ Use Retin A/ Renova/ Differin / Tazovac /Avage?
- ☐ History of Accutane use?
- ☐ Take Asprin?
- ☐ Take Plavix?
- ☐ Other blood thinners?
- ☐ Are you post-menopausal?
- ☐ Are you or could you be pregnant?
- ☐ Would you agree to a blood transfusion in a life threatening case?
- ☐ Fibromyalgia?
- ☐ History of depressions?
- ☐ Psychiatric disorder?
- ☐ Nerve injury/neuropathy?
- ☐ Numbness?
- ☐ Chronic pain?
- ☐ Uneven pigmentation
- ☐ Have Permanent Makeup?
- ☐ Habit of tanning or use of self tanner?

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Fellow, American Academy of Facial Plastic and Reconstructive Surgeons
(360) 830-1755 | 2011 NW Myhre | Silverdale, WA

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CHI Franciscan Health
Our best care. Your best health.℠

Locations of concern / Areas of improvement

☐ Face—fine wrinkles
☐ Face—deep wrinkles/folds
☐ Eyebrows—sagging
☐ Eyelids—upper, baggy
☐ Eyelids—lower, baggy
☐ Nose—size, shape, refinement
☐ Nose—improve nasal breathing
☐ Cheeks—improve fullness
☐ Skin—improve texture, appearance
☐ Mouth—downturned corners
☐ Chin—recessed
☐ Chin—jowling (“turkey waddle”)
☐ Scars—prominent
☐ Removal of skin lessions
Other ________________________

____

Describe your skin:

☐ Normal
☐ Dry
☐ Combination
☐ Oily
☐ Acne
☐ Clogged Pores
☐ Rosacea
☐ Eczema
☐ Freckled
☐ Mature
☐ Sallow
☐ Melasma
☐ Psoriasis
☐ Spider Veins
☐ Patchy Dryness
☐ Wrinkled
☐ Sun Damaged
☐ Redness
☐ Uneven Pigmentation
☐ Unwanted Hair
☐ Complexion Improvement

Medications

Please list ALL medications you are taking. Include over the counter medications, remedies, supplements, herbs and vitamins:

____
____
____
____

Cosmetic Procedures

Have you had any cosmetic procedures including lasers, peels, injectable fillers, BOTOX, etc.?
☐ Yes ☐ No

____
____
____
____

Surgical Procedures

Please list ALL surgical procedures (including cosme surgery) and dates:

____
____
____
____

Allergies

Please list any allergies to medications, food, dyes, tape, latex, etc.:

____
____
____
____

Medical Conditions / Problems

Do you have any current or past medical conditions / problems? ☐ Yes ☐ No

____
____
____
____

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Family History or any major medical problems?

____
____
____
____

Are you allergic or sensitive to? (check all that apply)

- ☐ Milk
- ☐ Apples
- ☐ Citrus
- ☐ Grapes
- ☐ Aloe Vera
- ☐ Aspirin
- ☐ Perfume
- ☐ Latex
- ☐ Hydroquinone

To the best of my knowledge, the information provided is true and complete.

____
Signature

____
Print Name

____
Date