



CAVALON AESTHETICS

COSMETIC SURGERY AND SKIN REJUVENATION

Patient Health Questionnaire

Today's Date:

Name:

DOB:

Sex: F M

Email:

Mailing Address:

Home Phone:

Cell Phone:

Work Phone:

Emergency Contact Name and Relationship:

Emergency Contact Phone Number:

Primary Care Physician:

Referred by:

Name/Source:

Patient of Dr. Henderson

Friend or Acquaintance

My Doctor

Attended Educational Program

Web Site

Advertisement

Other

May we send a thank you to the person listed above? Y N

Health History

Do you smoke?

Drink alcohol?

Diabetes?

Ashtma/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 Aspirin?

Take Plavix?

Other blood thinners?

Are you post-menopause?

Are you/could be pregnant?

Would you agree to a blood

transfusion in a life

threatening case?

Fibromyalgia?

History of depression?

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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(360) 830-1755 | 2011 NW Myhre Rd. | Silverdale, WA



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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 lesions
- 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.?

Y N

Surgical Procedures

Please list ALL surgical procedures (including cosmetic 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?

Y N

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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