Virginia Mason Franciscan Health

TDC
THE DOCTORS CLINIC
A part of Franciscan Medical Group

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:

- ☐ Patient of Dr. Henderson
- ☐ Friend or Aquaintance
- ☐ My Doctor
- ☐ Attended Educational Program
- ☐ Web Site
- ☐ Advertisement
- ☐ Other

Name/Source: _____

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?

Jenifer L. Henderson, M.D., F.A.C.S.
Fellow, American Academy of Facial Plastic and Reconstructive Surgeons
(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

Hae 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

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