Institute for Beauty, Wellness & Regenerative Medicine

PLEASE PROVIDE THE RECEPTIONIST WITH YOUR PHOTO ID

Patient's Name _____
First, Middle, Last Date

Address _____
Street & Apt # City State Zip

Home Phone _____ Cell Phone _____ Other Phone _____

Any restrictions for contacting you? ▫ No ▫ Yes E-mail _____

Contact Restrictions: _____

Age _____ Birthdate ____/____/____ SS# _____ Gender: Female Male Transgender

Relationship Status : Single Engaged Married Divorced Widow Partner Other

Patient's Employer _____ Occupation _____

Work Phone _____ Ext: _____ Is it okay to call you at work? ▫ Yes ▫ No

Address _____
Street & Suite # City State Zip

How did you hear about Dr. Nicole? (mark all that apply)

▫ TV News ▫ Magazine ▫ Seminar ▫ Salon ▫ Web

▫ Friend/Relative: _____ ▫ Doctor: _____ ▫ Other: _____

If you were referred by a specific person, may we thank them? ▫ Yes ▫ No

Emergency Contact _____ Relationship to Patient _____

Home Phone _____ Work Phone _____ Cell Phone _____

Areas of Interest: (mark all that apply)

Facial Procedures

▫ PRP treatment
▫ Eyelid rejuvenation
▫ Botox™ / Dysport
▫ Brow Lift
▫ Face rejuvenation
▫ Micropen microneedling
▫ Laser Skin Resurfacing
▫ Lip Enhancement
▫ Facial Fat Transfer
▫ Wrinkle Fillers (Injections)
▫ Microblading (eyebrow tattoo)
▫ VENUS Legac/Freeze
▫ Juliet vaginal rejuvenation

Breast/Body Procedures

▫ Breast augmentation
▫ Breast Implant removal
▫ Gynecomastia Treatment
▫ Breast Reduction
▫ Mastopexy (Breast Lift)
▫ Abdominoplasty (Tummy Tuck)
▫ Brachioplasty (Arm Lift)
▫ Thigh or Buttock Lift
▫ Laser liposuction – abdomen, hips, thighs, arms, other
▫ Labiaplasty
▫ O Shot (PRP) sex/urinary incontinence
▫ Permanent makeup- eye liner, lip blushing

Other Procedures

▫ Hair loss treatment
▫ Skin Care
▫ Vaginal atrophy/tightening
▫ Cellulite reduction
▫ Lesions / Moles / Warts
▫ Hand Rejuvenation
▫ Nutritional Supplements
▫ Latisse™
▫ Spider Veins
▫ Mineral makeup
▫ Laser hair removal
▫PRP for hair loss

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▫ Secret RF (microneedling w/ radiofreq.) ▫ Y-lift nonsurgical facelift

Patient name:

Date of birth: Age:			Weight lbs Height ft in		
What surgery or procedure(s) are you considering?			**OFFICE USE ONLY** **BMI =**		
Migraine Headaches	Yes	No	Glaucoma	Yes	No
History of skin cancer (list type & location if known):	Yes	No	Other eye problems : please specify	Yes	No
Skin Disorders – eczema, psoriasis, vitiligo or other skin condition	Yes	No	Glasses or contacts	Yes	No
Heart Procedure	Yes	No	Use of eye drops (any type)	Yes	No
Palpitation or Irregular Pulse	Yes	No	LASIK eye surgery	Yes	No
Heart Attack	Yes	No	Yellow Jaundice	Yes	No
Stroke	Yes	No	Gallstones/Gallbladder Trouble	Yes	No
Hypertension (high blood pressure)	Yes	No	Cirrhosis of the Liver	Yes	No
Blood Pressure Abnormalities	Yes	No	Alcoholism or Drug Dependency	Yes	No
Abnormal EKG	Yes	No	Esophageal Varices	Yes	No
Rheumatic Fever	Yes	No	Heartburn or Indigestion	Yes	No
Heart Failure	Yes	No	Ulcers	Yes	No
High cholesterol	Yes	No	Gastritis	Yes	No
Shortness of Breath	Yes	No	Colitis	Yes	No
Chest Pain	Yes	No	Constipation	Yes	No
Asthma	Yes	No	Vomiting Blood	Yes	No
Bronchitis	Yes	No	Tarry or Bloody Bowel Movements	Yes	No
Pneumonia	Yes	No	Goiter or Thyroid Disorders	Yes	No
Tuberculosis	Yes	No	Diabetes	Yes	No
Smokers Cough	Yes	No	Autoimmune disease (please specify)	Yes	No
Emphysema	Yes	No	Arthritis	Yes	No
Coughing/ Spitting of Blood	Yes	No	Fracture of Neck or Spine	Yes	No
Hay Fever or major allergies	Yes	No	Bleeding Tendency or Disorder	Yes	No
Back Pain	Yes	No	Abnormal Bleeding After Tooth Extraction	Yes	No
Palsy or Paralysis	Yes	No	Breast Cysts, Tumors, Abscesses	Yes	No

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Kidney Disorder	Yes	No	Nipple Discharge (apart from lactation)	Yes	No
Mammogram or breast ultrasound	Yes	No	Nervous Breakdown or Anxiety Disorder	Yes	No
Insomnia	Yes	No	Hot flushes or other peri-menopausal symptoms	Yes	No
Poor sleep – difficulty falling or staying asleep	Yes	No	Missed or irregular menstrual cycle	Yes	No
Recreational illegal drug use	Yes	No	Radiation treatment in the past (if yes, list area treated):	Yes	No
Seizures, Convulsions, Fainting	Yes	No	Piercing other than the ears	Yes	No
Black outs	Yes	No	Dentures, bridges, crowns, cosmetic bonding to teeth	Yes	No
Blood Transfusion	Yes	No	Loose teeth or periodontal disease	Yes	No

Positive blood test for HIV, AIDS, Hepatitis	Yes	No	Chemical peels or microdermabrasion	Yes	No
Family history of cancer, heart disease or stroke	Yes	No	IPL/fotofacial	Yes	No
Family members with anesthesia problems	Yes	No	Laser hair removal – if yes, please list areas treated:	Yes	No
Family members with bleeding or clotting problems	Yes	No	Current or recent use of diet pills	Yes	No
Psychiatric Hospitalization or Care	Yes	No	Weight increase or decrease >5 lbs in last 6 months (if yes, circle which)	Yes	No

1) **Please list all present medications**, including birth control pills, hormones, vitamins, herbal medication, diuretics, and weight loss drugs. **Include over-the-counter medications.**

_____

_____

_____

2) **Allergies and Sensitivities:**

Local Anesthetics…… Y / N
Antibiotics (Penicillin/other)…… Y / N
Morphine or Codeine……Y / N
Latex……Y / N

General Anesthetics…….. Y / N
Barbiturates, Sedatives…….. Y / N
Adhesive Tapes..…… Y / N

3) Do you react abnormally to any medication? □ Yes □ No Which?_____

4) Have you, or any member of your family, ever had any difficulties with any medications, drugs, or gases used for anesthesia?

□ Yes □ No

If yes, what was the medication & reaction?_____

5) Have you ever been on cortisone or steroid treatment? □ Yes □ No When? _____

6) Do you consume alcoholic beverages, including beer, wine, or other alcohol? □ Yes □ No

If yes, how much? _____

7) Do you smoke or use any nicotine products? □ Yes □ No If yes, what?_____

Frequency?_____

8) Are you pregnant? □ Yes □ No When was your last normal menstrual period?_____

What form, if any, of birth control are you using?_____

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Have you ever had the following? Please comment if yes.

- Current or history of skin cancer, especially malignant melanoma or recurrent non-melanoma skin cancer, or pre-cancerous lesions. ☐ Yes ☐ No
- Any active infection (including dental, sinus, urinary tract or STD). ☐ Yes ☐ No
- History of fever blisters/cold sores and/or genital herpes. ☐ Yes ☐ No
- Any history of gingivitis or recurrent UTI's ☐ Yes ☐ No
- Diseases which may be stimulated by light at 790-830 nm, such as history of recurrent Herpes Simplex, Systemic Lupus Erythematous, or Porphyria.. ☐ Yes ☐ No
- Use of photosensitive medication and/or herbs that may cause sensitivity to 790-830 nm light exposure, such as Isotretinoin (Accutane), tetracycline, or St. John's Wort. ☐ Yes ☐ No
- Immunosuppressive diseases, including AIDS and HIV infection, or use of immunosuppressive medications(such as chemotherapy medications) ☐ Yes ☐ No
- History of radiation treatment. If yes, please list area treated: _____ ☐ Yes ☐ No
- History of connective tissue diseases, such as rheumatoid arthritis, lupus or scleroderma ☐ Yes ☐ No
- History of keloid scarring. ☐ Yes ☐ No
- History of hormonal or endocrine disorders, such as polycystic ovary syndrome or diabetes, unless under control. ☐ Yes ☐ No
- Very dry skin. ☐ Yes ☐ No
- Exposure to sun or artificial tanning during the 3–4 weeks prior to treatment. ☐ Yes ☐ No
- History of a DVT (deep venous thrombosis) and/or PE (pulmonary embolism) ☐ Yes ☐ No
- History of foot swelling or leg edema or wounds/ulcers on your feet or legs ☐ Yes ☐ No
- History of aching, heaviness, itching, burning in your legs ☐ Yes ☐ No
- Tanning bed or sun tanning within the past 6 weeks ☐ Yes ☐ No
- Spray tanning in the last 4 weeks ☐ Yes ☐ No

9) How many pregnancies_____ Births? _____ Breast fed? ☐ Yes ☐ No If yes, how long?_____

CHILDREN (list names and ages or birthdates):_____

_____

10) When was your last physical exam?_____ By whom?_____

11) When was your last eye exam?_____ Dental cleaning ?_____

12) When was your last chest x-ray?_____ EKG?_____

13) Who is your personal physician, if any?_____

Please list all physicians presently caring for you & include specialty, if known

_____

_____

14) Have you ever been under psychiatric care or in a substance abuse program? ☐ Yes ☐ No

If yes, when? _____ for what? _____

15) Have you had any recent blood work done? ☐ Yes ☐ No When?_____

16) Is there anything else you think the doctor should know?_____

17) Please list all hospitalizations and surgeries, including procedures done for cosmetic reasons:

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SURGICAL OPERATIONS (include where, when, why & complications for each surgery):

_____

_____

_____

_____

_____

HOSPITALIZATIONS (include where, when, and why for each admission) :_____

_____

_____

_____

18) Have you had any recent weight gain/loss? _____

19) Is there any reason you would not accept a transfusion in an emergency situation? □ Yes □ No

Photo Authorization

The use of photographs is essential to the planning and evaluation of cosmetic surgery. Your surgery or procedure will be photographically documented before, and after the procedure. These photographs are a permanent part of your medical record and will never be shown to anyone else without your consent. For various reasons, Dr. Nicole Castellese is often asked to show before and after photos of patients. Most patients, happy with their results, give permission to use their photos anonymously. At your request, any identifying marks, such as birthmarks or tattoos can be blacked out, and for facial pictures, the eyes may be blacked out. Please note below if such modifications are requested.

I _____ hereby grant Dr. Nicole Castellese/Institute for Beauty, Wellness & Regenerative Medicine and staff permission to photograph me. I further give my irrevocable consent to publish, republish or otherwise transmit the images of myself in any medium for all purposes throughout the world. I understand that the images may be altered or modified in any manner. I understand that every attempt will be made to represent me and Nicole Castellese, MD accurately and with integrity and dignity in all media. I hereby certify that I have read the foregoing and fully understand its meaning and effect.

Please initial areas that may be shown: _____Nonsurgical face _____Nonsurgical body _____Surgical Body _____No areas may be shown

Please list specific requests here:_____

Signature_____ Date_____

Witness _____ Date_____

I understand that office visit charges are payable on the day service is rendered

I, the undersigned, represent that all of the information on this form is true and complete to the best of my knowledge and that I accept full financial responsibility for professional, medical and surgical services rendered.

Patient Signature: _____

Print Name: _____ Date:_____