Precision Aesthetics & Wellness

83 S Bedford Rd. Suite 100, Mount Kisco, NY 10549
P 914 218-8800 F 914 218-8799

Date:_____

PATIENT INFORMATION

Name(Last, First, Middle Initial)			**How did you hear about us?**
Home Address		**City**	**State** **Zip**
Birthdate _____/_____/_____	**Social Security #**	**Gender** Male ☐ Female ☐	**E-mail address**
Age:	**Height:**	**Weight:**	
Cell Phone # **( )_____**	**Home Phone #** **( ) _____** *Please indicate best phone # to reach you	**Work Phone #** **( )_____**	
Employer	**Employer's Address (city, state, zip)**		
Employment Status Employed ☐ Unemployed ☐ Student ☐ Retired ☐ Other ☐		**Marital Status** Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐	

IN CASE OF AN EMERGENCY, WHO SHOULD WE CONTACT?

Name		**Work Phone #** **( )**	**Home Phone #** **( )**
Street Address	**City** **State** **Zip**		**Relationship to Patient**

MEDICAL INFORMATION

ALLERGY & SENSITIVITY INFORMATION

Please list all allergies and sensitivities and any reactions that you have experienced:

WHAT PRESCRIPTION and DOSAGES and/or OVER-THE-COUNTER MEDICATIONS ARE YOU TAKING?
(e.g. medicines for constipation, sleep, headache (aspirin), birth control, anxiety, etc…) Please list:

SURGERY & PRIOR HOSPITALIZATION INFORMATION:

Please list & give approximate dates:

PRIOR & CURRENT MEDICAL CONDITIONS:

Please list & give approximate dates:

REVIEW OF SYSTEMS

Please answer the following Yes or No questions to the best of your ability. Do you have or had any of the following conditions, illnesses or symptoms?

Current/ Past History **Please circle or check all that apply**	**YES**	**NO**	**STAFF COMMENTS:**
Abdomen: Hernia, Bariatric or other Abdominal Port			
Auto Immune: Rheumatoid Arthritis, Psoriasis, Lupus, Scleroderma, Fibromyalgia, MS			
Cancer: Active, Remission, Chemotherapy, Radiation			
Cardiovascular: Heart Attack, Irregular Heartbeat, Hypertension, Edema, Aneurysm, Angina, Angioplasty, Stent, Pacemaker, Defibrillator, Abnormal Stress Test			
Endocrine: Diabetes, Thyroid			
Gastrointestional: Ulcers, Bleeding, Salivary Gland Removal including parotidectomy			
Hematology: Anemia, Bleeding Disorder, Platelet Disorder, Easy Bruising, Blood Clots (DVT/ PE)			Coumadin [_]Y [_]N
Hepatic: Hepatitis, Other Liver Disease			
HIV/ AIDS			
Neurological: Seizures, Stroke, Headaches, Dizziness, Brain Aneurysm, Shunt, Restless Leg Syndrome			Last Seizure:
Ocular: Severe Dry Eyes, Bell's Palsy, Cataracts, Glaucoma			
Psychiatric: Depression, Anxiety			
Renal: Kidney Infection or Disease, Decreased Function			
Respiratory: Asthma, COPD, Emphysema, Breathing Problems, Cough			Oxygen [_] Y [_] N
Sleep Apnea [_] CPAP/ BIPAP [_] Oxygen			
Skin: Poor Healing, Increased Scarring (Keloids), Rashes, Sores, MRSA, MDRO			
Weight: Recent Unexplained Weight Gain/ Loss (10lbs or more)			
Surgical History:	**YES**	**NO**	**STAFF COMMENTS:**
Prior Liposuction			
Prior Facial Procedures (Surgery, Botox, Fillers, Laser Resurfacing)			
Other Past Surgeries (Bariatric, Abdominoplasty, Breast, etc.)			
Past Surgical or Anesthesia Complications			
Social History:	**YES**	**NO**	**STAFF COMMENTS:**
Do you smoke now? [_] Yes [_] No If yes, type/ frequency?			
Did you ever smoke? [_] Yes [_] No If yes, for how long? When did you quit?			
Do you drink alcohol? [_] Yes [_] No If yes, type/ frequency?			
Illicit Drugs If yes, type/ frequency:			
Narcotic Pain Meds: If you have a current script, please provide the following.			
Physician Name: Phone:			[_] Previous [_] Current
Family History:			
[_] None [_] Cancer [_] Cardiac [_] Respiratory [_] Bleeding Disorder			
[_] Anesthetic Reaction [_] Stroke [_] DVT/ PE			
***FEMALES ONLY:* Current/ Past History**	**YES**	**NO**	**STAFF COMMENTS:**
Pregnancy: Within 3 Months of Vaginal Delivery; 6 months of C-Section; Breast Feeding			
Hysterectomy: Complete Absence of Menstrual Periods			
Obstetrics: Number of Vaginal Births: C-Sections: Still Births:			

This is a confidential report of your medical history and will be kept in this office. Information contained herein will not be released to any person or organizations except when you have authorized us to do so.

PLEASE STATE THE REASON/S FOR YOUR VISIT:

My signature below verifies the following:

- **The information provided regarding medical and contact information is true to the best of my knowledge.**
- **I am the only one with access to this information unless otherwise specified.**
- **I give my permission to Dr Dayna McCarthy, Dr Neil Goodman and staff to contact me at the phone numbers I provided.**
- **I have been given the HIPPA Privacy notice to read and review.**

PATIENT'S SIGNATURE: _____ **DATE:** _____

CONSULTATION COMMENTS: