

Patient's Name _____
Last First Middle

Address _____
Street & Apt # City State Zip

Home Phone _____ Cell Phone _____ Other Phone _____

Any restrictions for contacting you? No Yes → Do not call or mail to: _____

Email (if permitted) _____ Drivers License # (include State) _____

Age _____ Birthdate ____/____/____ SS# ____-____-____ Sex Female Male

Marital Status Single Married Divorced Widowed _____

Patient's Employer _____ Occupation _____

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

Address _____
Street & Suite # City State Zip

Emergency Contact & Relationship: _____ Daytime phone # _____

Spouse's Name _____ Occupation _____ Cell number _____

Employer _____ Work number: _____

So that we may complete your chart for your consultation with Dr. Johnson's please specify all procedures you may wish to discuss. (please check all that may apply)

- Facelift, Cheeklift, Necklift Eyes Forehead Liposuction Abdominoplasty Arm Lift Thigh Lift
- Laser Skin Nose Chin or Cheek Implants Buttock/Thigh Lift **Breast surgery:** Implants Lift Reduction

For out of state/town patients:

We need a local phone number/address to reach you : _____

We appreciate you letting us know how you were referred to Dr. Johnson or our office:

- Website: _____ Friend/Patient: _____ Yellow pages Dr. _____
- other _____

I authorize the release of my medical records to physicans or persons providing healthcare to myself, under section 12-2294 (d) an Arizona Statute. (We will make every effor to contact you prior to releasing information). Dr. Johnson's office has my permission to call in any and all prescriptions or lab orders necessary for my treatment. I understand that pre and post-operative photographs will be taken,should I choose to have surgery or procedures peformed by Dr. Johnson or staff members. These photograpsh shall remain the property of Martin L. Johnson, M.D., for the purpose of educating and teaching.

Dr. Johnson is no longer contracted with health insurance plans (some insurance books continue to list Dr. Johnson as a provider). All visits are considered elective/cosmetic. Payment is expected at the time of visit. Acceptable forms of payment include: Visa, MC, Amex, Discover, Cash, Checks and referral to a financing plan.

Signature _____ **Date** _____

Center For Skin Care

Under the Direction of Dr. Martin L. Johnson

Skin Evaluation

Patient: _____ **Date:** _____

Have you ever seen a dermatologist for your skin? Yes No
Have you ever used Accutane? Yes No
Are you allergic to any medications? Yes No Please list: _____
What topical medications do you use or have you used: Acne Retin – A Glycolic Acid
 Other: _____

Please check which oral medications you currently use or have used: Tranquilizers Antibiotics
 Diuretics Hormones Birth Control Other: _____

Please list current products you use for your daily skin care regime: _____

Does your skin ever flake or feel tight and dry? Frequently Occasionally Rarely
Is your skin “shiny” a few hours after cleansing? Frequently Occasionally Rarely
Do you experience blackheads or blemishes? Frequently Occasionally Rarely
Have you ever had a skin allergy or rashes? Yes No
Do you have any skin allergies to: Cosmetics Fabrics Aspirin Other: _____

Do you smoke? Yes No If yes, how much _____
Do you consume alcohol? Yes No If yes, how much _____
Do you have a healthy diet? Yes No
Do you exercise regularly? Yes No
Do you take daily herbs/vitamins? Yes No If yes, please list type: _____

Where do you think you have facial wrinkles? Eyes Forehead Mouth Neck
What type of facial wrinkles do you think you have? Fine Deep
Do you think your skin is fragile and do you sunburn easily? Yes No
Have you ever suffered a bad sunburn? If yes, when? Yes No When: _____
Do you form thick or raised scarring from a cut or burn? Yes No
Do you wax or use depilatories on your face? Yes No
Do you ever get cold sores? Yes No

Have you or any member of your family had skin cancer? Yes No
If yes, please identify relationship & location of skin cancer: _____

How would you like to improve your skin? _____

What specific areas would you like to focus on? Face Neck Chest Back Hands
 Forearms Lower Legs Other: _____

Signature: _____ **Date of Birth:** _____ **Date:** _____

Health History (2 sides)

Name: _____ Age: _____

Height: _____ Weight: _____ Sex: _____

Name of Family Physician: _____

Please state the reason you are seeing the doctor: _____

Do you smoke or use nicotine products? Yes No How much? _____ How Long? _____

Are you presently taking any medications? Yes No

List Medication Name	Dosage and	How often taken:
_____	_____	_____
_____	_____	_____

Do you take vitamin supplements? Yes No ...use any medicated skin creams, ointments? Yes No

Do you have mitral valve prolapse? Yes No Do you have a heart murmur? Yes No

Are you allergic to any medications? Yes No

List Medication Name and type of Allergic Reaction Experienced:

Are you allergic to: Soybean Yes No, Eggs Yes No, Latex Yes No

Do you take aspirin or aspirin products routinely? Yes No

Have you ever had any surgical operations? Yes No

List Date and	Surgery
_____	_____
_____	_____

Have you ever had any cosmetic operations? Yes No

List Date and	Procedure
_____	_____
_____	_____

Have you ever required hospitalizations for any serious medical illness? Yes No

List Date and	Medical Condition Suffered
_____	_____
_____	_____

Family History: Do you have a family history for any of the following disorders?

- | | | |
|--|---|---|
| <input type="checkbox"/> Yes <input type="checkbox"/> No Breast Cancer | <input type="checkbox"/> Yes <input type="checkbox"/> No Diabetes | <input type="checkbox"/> Yes <input type="checkbox"/> No Lung Disease |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Bleeding or Blood Disorders | <input type="checkbox"/> Yes <input type="checkbox"/> No Epilepsy | <input type="checkbox"/> Yes <input type="checkbox"/> No Heart Disease |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Cancer _____ | <input type="checkbox"/> Yes <input type="checkbox"/> No Asthma | <input type="checkbox"/> Yes <input type="checkbox"/> No Kidney Disease |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Tuberculosis (T.B.) | <input type="checkbox"/> Yes <input type="checkbox"/> No Stroke | |

Additional information, which you feel, should be known before you undergo any type of surgery (i.e. **special catheter, no latex, tape allergies**)

I have completed all applicable questions on the "Patient Health History." The above facts are true and correct to the best of my knowledge.

Signature of Patient or Responsible Guardian _____ Date _____

Have **you** ever had any of the following problems?

LUNGS (PULMONARY)	YES	NO
Bronchitis	_____	_____
Emphysema	_____	_____
Asthma	_____	_____
Wheezing	_____	_____
Pneumonia	_____	_____
Tuberculosis (T.B.)	_____	_____
Chronic or Frequent Cough	_____	_____
Shortness of Breath	_____	_____
Abnormal Chest X-Ray	_____	_____
Any Lung Disease	_____	_____
Chronic Nose/Sinus Complaints	_____	_____

HEMATOLOGIC	YES	NO
Blood Clots in your Legs	_____	_____
Pulmonary Embolism	_____	_____
Phlebitis	_____	_____
Varicose Veins	_____	_____
Easy Bleeding Tendency	_____	_____
Easy Bruising Tendency	_____	_____
Blood Clotting Abnormalities	_____	_____
Blood or Plasma Transfusion	_____	_____
Hemophilia	_____	_____
Recurrent Nosebleeds	_____	_____

GASTROINTESTINAL	YES	NO
Jaundice or Hepatitis	_____	_____
Liver Disease	_____	_____
Stomach Ulcers	_____	_____
Frequent Heartburn	_____	_____
Hernia	_____	_____

RENAL	YES	NO
Kidney Disease/Stones	_____	_____
Frequent Bladder Infections	_____	_____
Prostate Problems	_____	_____

SKIN	YES	NO
Have you had Skin Cancer	_____	_____
Chronic Skin Condition (hives, eczema, rashes)	_____	_____
Form Large Scars/Keloids	_____	_____
ACTH / Steriod Medications (excluding skin creams/lotions)	_____	_____
Allergic to Suture Materials (Catgut)	_____	_____
Frequent Infections/Boils	_____	_____
Cold Sores/Fever Blisters	_____	_____

NEUROLOGICAL	YES	NO
Stroke	_____	_____
Fainting Spells	_____	_____
Convulsions	_____	_____
Seizures	_____	_____
Epilepsy	_____	_____

CARDIOVASCULAR	YES	NO
Mitral Valve Prolapse	_____	_____
Anemia	_____	_____
High Blood Pressure	_____	_____
Chest Pain / Angina	_____	_____
Heart Attack	_____	_____
Irregular Heartbeats	_____	_____
Congestive Heart Failure	_____	_____
Rheumatic Fever	_____	_____
Heart Murmurs	_____	_____
Heart Block	_____	_____
Low Potassium	_____	_____
Abnormal EKG (heart recording)	_____	_____
Pacemaker	_____	_____
Any Heart Disease	_____	_____
Sickle Cell Disease	_____	_____

MUSCULOSKELETAL	YES	NO
Chronic Back Pain	_____	_____
Chronic Neck Pain	_____	_____
Arthritis	_____	_____
Bone, Joint, Muscle Trouble	_____	_____

METABOLIC	YES	NO
Recent Unexpected Weight Loss	_____	_____
Diabetes	_____	_____
Thyroid / Goiter Problems	_____	_____
Night Sweats / Fever	_____	_____
AIDS (HIV +)	_____	_____

VISION	YES	NO
Glaucoma	_____	_____
Loss of Vision	_____	_____
Radial Keratotomy	_____	_____
Wear Glasses	_____	_____
Wear Contacts	_____	_____
Lasik	_____	_____

MENTAL	YES	NO
Do you have, or have you had Significant Emotional Problems?	_____	_____
Any Recent Emotional Crisis?	_____	_____

LADIES	YES	NO
Any Possibility You Are Pregnant?	_____	_____

BREAST SURGERY PATIENTS	YES	NO
Have you had a mammogram? When? _____	_____	_____

