



Cardinal Internal Medicine
Aesthetics

PATIENT MEDICAL INFORMATION

Patient's Name: _____

Which procedure are you interested in? Botox Dermal Fillers Chemical Peel
 Brow lift Other/Specify _____

Are you pregnant? Yes No Are you breastfeeding? Yes No

Please make a check mark beside any of the following medical illnesses that you may have:

- | | | |
|--|--|---|
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Stomach Problems | <input type="checkbox"/> Anemia |
| <input type="checkbox"/> Diabetes (Type__) | <input type="checkbox"/> Bleeding Problems | <input type="checkbox"/> Eye Problems |
| <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Thyroid Problems | <input type="checkbox"/> Neurological Disorders |
| <input type="checkbox"/> Breathing Problems | <input type="checkbox"/> Mental Problems | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Kidney Problems | <input type="checkbox"/> Keloids or Hypertopic Scars | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Mitral Valve Prolapse | |

When were you last tested for HIV? _____ Positive/Negative results?

Have you ever been treated for any psychiatric problems? No Yes
explain _____

Have you had any recent surgeries (Last 3months)? _____ Date _____

Are you planning to have surgery in the near future? No Yes
explain _____

What medications are you currently taking? _____

Are you taking vitamin "E"? Yes No

Do you take aspirin or any blood thinners? Yes No
If yes please list: _____

Do You Smoke? Yes No
How often do you smoke? _____ How long have you been smoking for? _____

Do you have a primary physician? Yes No Who? _____

Signature

Date