

LUCIAN J. RIVELA, M.D., F.A.C.S.
PATIENT INFORMATION

NAME: _____

DOB: _____ AGE: _____ SS# (OPTIONAL): _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

HOME PHONE: _____ WORK PHONE: _____

CELLULAR: _____ PLEASE CIRCLE PREFERRED CONTACT NUMBER

PHARMACY PHONE NUMBER: _____

MARITAL STATUS: M D S W SEP

REASON FOR VISIT: _____

OTHER AREAS OF CONCERN/OR PROCEDURES YOU ARE INTERESTED IN SUCH AS:

Fine Lines and Wrinkles Major Lines around nose and mouth Age Spots/Sun Spots

Spider Veins Unwanted Hair Bags under eyes or eyelids Breasts

Excess fullness/loose skin in ABS Excess fullness in the hips, thighs or buttocks regions

Lip Size or Shape Other: _____

REFERRED BY: Newspaper Magazine Ad Phone Book Previous Patient
 Internet Physician Other

PLEASE LIST REFERRAL NAME/LOCATION: _____

EMERGENCY CONTACT

NAME: _____ RELATIONSHIP: _____

HOME PHONE: _____ WORK PHONE: _____

PATIENT'S EMPLOYER INFORMATION

EMPLOYER: _____ PHONE# _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

SIGNATURE: _____ DATE: _____

Lucian J. Rivela, M.D., PA
HEALTH HISTORY

Patient Name: _____ Date: _____

Age: _____ Date of Birth: _____ HT: _____ WT: _____ Marital Status: _____

What is the reason for your visit: _____

MEDICAL HISTORY: Do you, or have you had any of the following?

	Yes	No		Yes	No
Rheumatic Fever/Scarlet Fever	<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>
Heart Trouble	<input type="checkbox"/>	<input type="checkbox"/>	Kidney	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Eye Disease	<input type="checkbox"/>	<input type="checkbox"/>
Irregular Heartbeat	<input type="checkbox"/>	<input type="checkbox"/>	Liver Disease	<input type="checkbox"/>	<input type="checkbox"/>
Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Problems	<input type="checkbox"/>	<input type="checkbox"/>
Chest Pains	<input type="checkbox"/>	<input type="checkbox"/>	Chronic Lung Disease	<input type="checkbox"/>	<input type="checkbox"/>
Shortness of Breath	<input type="checkbox"/>	<input type="checkbox"/>	Blood Disorders	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Skin Diseases	<input type="checkbox"/>	<input type="checkbox"/>
Skin Sensitivity to Adhesive Tape	<input type="checkbox"/>	<input type="checkbox"/>	Large Scars or Keloids	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had psychiatric problems/been under the care of a psychiatrist?	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>

If you answered yes to any question, please explain: _____

HOSPITALIZATIONS AND/OR PREVIOUS SURGERY: Please list with dates:

ALLERGIES: Are you allergic to any medications? Yes No If yes, please list medication and type of reaction (s) _____

MEDICATIONS: Please list **all medications** you are currently taking, including herbal medicines, diet pills, accutane and over-the-counter medications. _____

FAMILY HISTORY:

Check (x) if blood relatives have had any of the following:

	<u>Relationship to you</u>	
<input type="checkbox"/>	Breast Cancer _____	
<input type="checkbox"/>	Skin Cancer _____	Type of skin cancer if know _____
<input type="checkbox"/>	Other skin diseases _____	Type if known _____
<input type="checkbox"/>	Keliod Scars _____	<input type="checkbox"/> Diabetes _____
<input type="checkbox"/>	Bleeding Disorders _____	<input type="checkbox"/> Heart Disease/stroke _____
<input type="checkbox"/>	Prolonged Bleeding _____	<input type="checkbox"/> Other _____

HEALTH HABITS: Do you smoke? No Yes _____ per day

WORK STATUS: Are you currently working? Yes Occupation: _____
No Retired

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any member of his staff responsible for errors or omissions that I may have made in completion of this form.

Signature _____ Date _____

Reviewed by _____ Date _____

Rivela Plastic Surgery

PATIENT SKINCARE AND LASER ASSESMENT FORM

Patient's Name: _____ Date: _____

Date of Birth: _____ Age: _____ Sex: _____

PERSONAL HISTORY

Are you currently seeing a physician for **any reason**? Yes No

If yes, explain reason: _____

Have you **ever** seen a physician or technician **specifically** for a skin problem or skincare? Yes No

If yes, when and for what reason: _____

Do you have any health problems? Yes No

If yes, please list: _____

Are you allergic to **ANY** medications: Yes No

Do you currently take **ANY** medications? Yes No

If yes, please list: _____

How do you want to improve your skin? _____

Do any of the following conditions relate to you?

Accutane or other similar medications:

Retin-A, Tazorac, Benzoyl Peroxide, Metrogel, Efudex, Cortisone, etc. Yes No

Allergies or skin sensitivities Yes No

Autoimmune disease, HIV, Lupus, Hepatitis Yes No

Blood thinner – Heparin, Coumadin, Warfarin, etc. Yes No

Cancer or post-cancer treatments Yes No

Cardiovascular problems Yes No

Cold sores or fever blisters Yes No

Cortisone or steroid injections Yes No

Cosmetic injections, fillers or implants, (i.e. Botox, collagen) Yes No

Eczema, psoriasis Yes No

Enlarged or painful glands Yes No

Epilepsy Yes No

Heart Ailment Yes No

Hypertension or high blood pressure Yes No

Moles, warts, keloids, pigmented scars, icepick scars Yes No

Light sensitive medication Yes No

PATIENT SKINCARE AND LASER ASSESMENT FORM CON'T

Loose, thin, aged skin	Yes	No
Oily or Acne prone skin (blackheads, whiteheads, large pores, cysts, etc.)	Yes	No
Pacemaker or metal implants	Yes	No
Phlebitis, varicose veins	Yes	No
Rosacea, telangiectasia/couperose	Yes	No
Type 1 Diabetic	Yes	No
Problems healing from a cut or burn	Yes	No

FREE RADICAL EXPOSURE

Do you smoke?	Yes	No	How much? _____
Do you consume alcohol?	Yes	No	How much? _____
Do you have a healthy diet?	Yes	No	List any dietary concerns: _____
Do you exercise?	Yes	No	How much? _____
Do you take Vitamins?	Yes	No	Multi-Vitamins: _____ Antioxidants: _____

FOR WOMEN ONLY

Are you going through menopause?	Yes	No
Are you pregnant or lactating?	Yes	No
Have you ever been pregnant?	Yes	No
If yes, during pregnancy did you ever experience _____ hyperpigmentation or "pregnancy mask"?	Yes	No
Do you have regular periods?	Yes	No
When was your last menstrual period? _____		

PIGMENTATION (Fitzpatrick Scale)

How do you tan? _____
I Burn _____ II Usually Burn _____ II Sometimes Burn _____ IV Rarely Burn _____
V Never Burn "Brown" _____ VI Never Burn "Black" _____

Hair Type: Coarse _____ Fine _____ Comments: _____
Natural Hair Color: Black _____ Brown _____ Red _____ Blonde _____ Gray _____
Other _____

PATIENT SKINCARE AND LASER ASSESMENT FORM CON'T

Presence of tattoos: _____ Location: _____

Frequency of use of the following modalities: Waxing _____

Mechanical epilation (plucking) _____ Electrolysis _____ Bleaching _____

Tanning history: _____

What specific areas do you want to treat?

Neck _____ Face _____ Chest _____ Back _____ Other _____

Patient Signature: _____ Date: _____

Physician Signature: _____ Date: _____