Boulder Valley Laser & Cosmetic

Andrew C. Goldman, M.D., Medical Director

Board Certified Facial Plastic Surgeon

Patient Information:

__________________________ ______ __________________________ Sex: F/M/NB
First Name M. Last Name

____
Home Address: Apt/Unit # City State ZIP

___________________ ______________________ _____________________________
Home Phone: Cell Phone: Email address:

DOB: ___________________ Age:___________

How did you hear about us? ____

Medical History:

List all medications you are currently taking or have taken in the last 6 months (prescription and OTC):

Medication (s) (Especially Aspirin) and Frequency:

_____________ _____________ _____________ _____________

Do you take herbal supplements and/or vitamins (especially Gingko, Ginger, Garlic, St. John's Wort, C, E, Fish oils)?:

____

List all drug allergies:

____

Are you a smoker? YES or NO If YES, how many cigarettes per day? : _______________

If you have quit, how long ago? ____

How much alcohol do you drink? ____________________ Caffeine? __________________

Have you had the following?

__Y __N Diabetes
__Y __N Asthma
__Y __N Currently Pregnant or Nursing

__Y __N Issues with Scarring
__Y __N Auto Immune
__Y __N Bleeding Disorders

List all surgeries that you have had: (Include Plastic Surgery)
Date: Surgery:

____

____

Have you or anyone in your family ever had unusual reactions to anesthesia? YES or NO

Have you ever had Botox injections? YES or NO

Have you ever had any type of Fillers? YES or NO

What type of Filler? ____

Your Skin Care

1. Have you ever had a facial treatment before? YES or NO

   If so, what type of treatment? ____

2. Have you ever had melasma (or chloasma)? YES or NO If so, when? _____________

   Has anyone in your family had melasma? ______________________________________

3. What is your ethnicity? ____

4. Have you ever had chemical peels, laser or microdermabrasion? YES or NO

   In the last month? YES or NO

5. Do you use Retin-A, Renova, Adapalene, Adapalene Hydroxyl Acid or Retinol/vitamin A derivative products? YES or NO
   a. Have you used any of these products in the last 3 months? YES or NO
      If yes, which one: ___________________________________
   b. Have you ever used Accutane? YES or NO When? _______ For how long?_______

6. Have you recently used any self-tanning lotions, creams or treatments? YES or NO
   If yes, please specify: _______________________________

I certify that the above information is true and correct, to the best of my knowledge.

Patient Signature: ___________________________________**Date:** ____________________