The LETT CENTER
Aesthetic & Reconstructive Surgery & Medi-Spa

MEDICAL & AESTHETIC QUESTIONNAIRE:
DATE: _____ DOB:_____
NAME:_____

HOW DID YOU HEAR ABOUT US?_____
WHAT ARE YOU BEING SEEN FOR TODAY AT THE LETT CENTER?_____

WHEN DID YOUR SYMPTOMS BEGIN?
WHERE DO SYMPTOMS OCCUR ON YOUR BODY?
DESCRIBE SYMPTOMS
PAIN ON A SCALE OF 1 (LEAST) TO 10 (WORST)
WHAT SITUATION CAUSES SYMPTOMS?
HOW LONG DO SYMPTOMS LAST?

HAVE YOU BEEN TREATED FOR THIS PROBLEM IN THE PAST? YES___ NO___ IF YES, WHEN?_____
DO YOU HAVE AN INTEREST IN ANY OF OUR AESTHETIC SERVICES? YES___ NO___ IF YES, WHAT?_____
HAVE YOU EVER SEEN A DOCTOR FOR YOUR SKIN? YES___ NO___ IF YES, PLEASE EXPLAIN_____

- I TAKE NO MEDICATIONS OR LIST MEDICATIONS BELOW INCLUDING OVER THE COUNTER VITAMINS, SUPPLEMENTS, PRESCRIPTION DOSAGES, AND ANY TOPICAL MEDICATIONS

- I HAVE NO ALLERGIES TO MEDICINES, OR LIST ALL ALLERGIES AND REACTIONS BELOW.

HAVE YOU EVER USED ANY OF THE FOLLOWING MEDICATIONS? YES___ NO ___ CHECK THOSE THAT APPLY

- HYDROQUINONE
- ACYCLOVIR
- RENOVA
- VALTREX
- TRETINOIN/RETIN-A
- ACCUTANE

ARE YOU PREGNANT? YES ____ NO____ ARE YOU TRYING TO GET PREGNANT? YES ____ NO ___
ARE YOU LACTATING? YES____NO_____ NUMBER OF PREGNANCIES _____
DID YOUR SKIN DARKEN/MASK WITH PREGNANCY? YES____ NO_____

- I HAVE HAD NO SURGERIES, OR LIST ALL SURGERIES INLCUDING COSMETIC/AESTHETIC SURGERIES BELOW

DATE	TYPE OF SURGERY	LOCATION/HOSPITAL	COMPLICATIONS?

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MARITAL STATUS:____ MARRIED____DIVORCED____SINGLE____WIDOWED____SEPARATED____
WHO LIVES WITH YOU?_____

TOBACCO USE (INCLUDING SNUFF, CIGARS, CHEWING TOBACCO, CIGARETTES, VAPOR, ETC):
YES___NEVER____ NOT NOW____IF YES, FREQUENCY & WHAT TYPE?_____

DRUG USE: YES___NEVER____NOT NOW____ IF YES, FREQUENCY & WHAT TYPE?_____

ALCOHOL USE: YES___NEVER___NOT NOW____ IF YES, HOW MUCH & HOW OFTEN?_____

THIS QUESTIONNAIRE IS FOR THE PAST 6 MONTHS ONLY, PLEASE CIRCLE IF IT APPLIES TO YOU.

GENRAL/ CONSTITUTIONAL	**GASTROINTESTINAL**	TROUBLE WALKING	DEPRESSION
GENERAL GOOD HEALTH	NAUSEA VOMITING	**RESPIRATORY**	FREQUENT HEADACHES
RECENT WEIGHT CHANGE	ABDOMINAL PAIN	SHORTNESS OF BREATH	PARALYSIS
NIGHT SWEATS, FEVERS	BOWEL PROBLEMS	COUGH	**BREAST**
FATIGUE	RECTAL BLEEDING	WHEEZING/ASTHMA	BREAST LUMP
MRSA	**ENT**	COUGHING UP BLOOD	BREAST PAIN
CARDIOVASCULAR	HEARING LOSS	**OPTHALMOLOGIC**	BREAST DISCHARGE
CHEST PAIN	EAR RINGING	WEAR GLASSES	**GENITOURINARY**
PALPITATIONS	SINUS PROBLEM	WEAR CONTACTS	BLOOD IN URINE
HEART PROBLEMS	NOSE BLEEDS	DOUBLE VISION	KIDNEY STONES
SWELLING HANDS/FEET	SORE THROAT	BLURRED VISION	**SEXUAL PROBLEMS**
ENDOCRINE	**MUSCULOSKELETAL**	EYE DISEASE/INJURY	**WOMEN ONLY**
EXCESSIVE THIRST	MUSCLE PAIN/CRAMPS	CHANGE IN HAIR/NAILS	MENSTRUAL PROBLEM
FREQUENT URINATION	STIFFNESS/SWELLING	RASH/ITCHING	DATE OF LAST PERIOD:
THYROID DISEASE	JOINTS	GLAUCOMA	
HORMONE PROBLEMS	JOINT PAIN	**NEUROLOGIC**	**MEN ONLY**
EASILY BRUISED		INSOMNIA	TESTICLE PAIN
		CONFUSION	

PAST MEDICAL HISTORY: CIRCLE ALL THAT APPLY

DIABETES	HEPATITIS	STROKE	FAINTING/DIZZINESS
MIGRAINES/HEADACHES		SEIZURES	BLOOD CLOTS
HEART DISEASE	HIGH BLOOD PRESSURE		SUBSTANCE ABUSE
CANCER (BREAST)			

HAVE YOU EVER HAD A MAMMOGRAM? YES___ NO___
IF SO, WHEN WAS YOUR LAST ONE?_____
WHAT'S YOUR WEIGHT?_____ HEIGHT?_____

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FAMILY HISTORY: CIRCLE ALL THAT APPLY

DIABETES	HEPATITIS	STROKE	FAINTING/DIZZINESS	
MIGRAINES/HEADACHES		SEIZURES	BLOOD CLOTS	
HEART DISEASE	HIGH BLOOD PRESSURE		SUBSTANCE ABUSE	CANCER

WHAT TYPE OF CANCER? AND WHOM?_____
PARENTS STILL LIVING? YES___ NO____

ADDITIONAL AREAS OF CONCERN FOR ME: CIRCLE ALL THAT APPLY

FINE LINES	WRINKLES	ROUGH TEXTURE OF SKIN	TIRED LOOKING SKIN
SAGGING SKIN	HAIR ON FACE	UNEVEN SKIN TONE	ACNE
FRECKLES	DRYNESS	BREAST SIZE	UNWANTED HAIR
DARK CIRCLE UNDER EYES		MAJOR LINES AROUND NOSE & MOUTH	

DO YOU TAN EASILY? YES___NO ____
DO YOU BURN EASILY DUE TO SUN/UV EXPOSURE? YES___ NO____
HAVE YOU OR DO YOU USE A TANNING BED? YES___ NO ____
DO YOU CURRENTLY SUN BATHE? YES____ NO____
DO YOU WEAR SUNSCREEN? YES___NO____
DO YOU CHECK YOUR SKIN MONTHLY FOR ABNORMALITIES? ____YES ____NO
DO YOU HAVE A HISTORY OF KELOIDS OR HYPERTROPHIC SCARRING?____YES____NO
HAVE YOU EVER BEEN TREATED WITH PHENOL OR TRICHLORACETIC ACID (TCA)? YES____ NO____ IF YES, WHEN?_____
HAVE YOU EVER HAD ANY LASER TREATMENTS? YES___ NO___ IF YES, WHAT TYPE & WHEN?_____
HAVE YOU EVER HAD ANY BOTOX OR DERMAL FILLER INJECTIONS?____YES ____NO, IF SO, PLEASE EXPLAIN WHICH ONES:_____
WHEN WAS YOUR LAST INJECTION?_____
DO YOU EASILY BRUISE WITH INJECTIONS?____YES____NO
DO YOU HAVE ANY COSMETIC IMPLANTS?____YES____NO, IF SO, WHAT TYPE?_____
WHAT TYPE OF SKINCARE DO YOU CURRENTLY USE?_____

DO YOU HAVE ANY OTHER CONCERNS? YES____ NO____ IF YES, PLEASE EXPLAIN:
