* **Required to answer**

New Patient History

Name:	Date of Birth:	Date:	
Sex:	Email:	Occupation:	
Address:	City:	State:	Zip:
Home Phone:	Cell:	Work Phone:	
Emergency Contact:	Phone Number:	Relationship:	

How did you hear about us? (Please check all that apply)

☐ Yelp ☐ Facebook ☐ Google Search ☐ Instagram ☐ Tik Tok ☐ Existing Patient

☐ Wechat ☐ Little Red Book ☐ Radio ☐ Newspaper ☐ Yellow Pages ☐ Others _____

☐ Friend (Name so we can thank them!) _____

Main Concern (s):

Face, Neck & Skin

- ☐ Signs of Aging-Fine Lines and Wrinkles
- ☐ Skin Pigmentation- Dark Spots and Uneven Tone
- ☐ Skin Laxity- Sagging
- ☐ Facial Contouring
- ☐ Acne, Acne Scars and Blemishes
- ☐ Enlarged Pores
- ☐ Skin Dullness
- ☐ Skin Redness or Broken Vessels
- ☐ Double Chin
- ☐ Turkey Neck
- ☐ Nose Contouring
- ☐ Hair Loss & Thinning
- ☐ Skin Lesions or Moles
- ☐ I Want to Prevent Aging

Body & Wellness

- ☐ Stubborn Fat Pockets Location: _____
- ☐ Stretchmarks Location: _____
- ☐ Skin Laxity
- ☐ Rectus Diastasis (separation of ab muscles)
- ☐ Cellulite
- ☐ Buttocks Sagging
- ☐ Breast Sagging
- ☐ Joint Pain Location: _____
- ☐ Surgical Scars Location: _____
- ☐ Difficulty with Weight Loss
- ☐ Fatigue
- ☐ Poor Sleep
- ☐ Bioidentical Hormone Replacement
- ☐ I'm Interested in the Newest Anti-Aging Treatments

Female Health

- ☐ Postpartum Rejuvenation
- ☐ Inability to Control Urine/Stool
- ☐ Urinary Urgency/Frequency
- ☐ Weak Pelvic Floor Muscles
- ☐ Vaginal Prolapse
- ☐ Poor Episiotomy Healing
- ☐ Hormone Imbalance
- ☐ I Want Cosmetic Surgery for Vagina/Labia
- ☐ I Don't Like the Way My Labia Looks
- ☐ My Labias are Larger than I Like
- ☐ Other Concerns, Please Specify:

Sexual Health

- ☐ Decreased Sexual Drive
- ☐ Difficulty with Orgasm
- ☐ Vaginal Laxity – Feels Loose or Air Leaks During Sex
- ☐ Decreased Sensitivity
- ☐ Vaginal Dryness
- ☐ Vaginal or Vulvar Pain
- ☐ Urine Leaks During Sex
- ☐ I Want My Hymen Repaired
- ☐ I Rely on My Genitalia Appearance at Work
- ☐ I've had Unflattering Comments about My Genital Area

_____

_____

Patient Name: _____ Date of Birth:_____

Skin Type

- ☐ Normal - Balanced with no dry areas or excess shine
- ☐ Oily - Excess shine and oil
- ☐ Sensitive - Prone to redness and blemishes
- ☐ Dry - Some dehydrated and dry areas
- ☐ Combination - Oily in T-zone with some dry areas
- ☐ I don't know

Previous Procedures: Which of the following have you had in the past?

Injectable

- ☐ Botox/Xeomin/Dysport/Jeuveau
- ☐ Dermal Fillers
- ☐ Radiesse
- ☐ Sculptra
- ☐ Bellafill
- ☐ Kybella
- ☐ Fat Transfer, location:_____
- ☐ Collagen or Silicone

Face/Neck Tightening or Lifting

- ☐ Ultherapy or HIFU
- ☐ Thermage
- ☐ Profound RF
- ☐ Thread Lift
- ☐ Face or Neck Lift

Hair Treatment

- ☐ Laser Hair Removal
- ☐ Hair PRP/Exosome Injections
- ☐ Hair Transplant

Skin Treatment

- ☐ Hydrafacial / Diamond Glow
- ☐ Chemical Peel, specify:_____
- ☐ Microdermabrasion
- ☐ Microneedling
- ☐ Aqua Injection / Mesotherapy
- ☐ IPL
- ☐ Fractional Laser
- ☐ Laser Skin Resurfacing
- ☐ Ablative Laser
- ☐ Lasers, specify:_____
- ☐ Picosecond Laser
- ☐ Tattoo Removal

Vaginal/Pelvis

- ☐ Vaginal Laser or RF treatment
- ☐ Thermiva
- ☐ Mona Lisa Touch
- ☐ O-Shot
- ☐ ALMI Femshot
- ☐ Emsella
- ☐ Labiaplasty/Vaginoplasty

Body

- ☐ Coolsculpting
- ☐ Sculpsure
- ☐ Emsculpt/Emsculpt NEO
- ☐ Body Contouring
- ☐ Stretchmark Treatment
- ☐ Botox for Body Contouring
- ☐ Renuvion
- ☐ Liposuction
- ☐ Breast Augmentation

Regenerative / Wellness

- ☐ IV Therapy
- ☐ Exosome or Stem Cell
- ☐ Bioidentical Hormone Therapy
- ☐ Joint Injections (PRP, Stem Cell)

Other Cosmetic Surgeries:

Specify:

- ☐ Others, specify:

Patient Name: _____ Date of Birth:_____

Past Medical History and Review of Systems: (please check all that apply)

☐ *Skip this section, I am completely healthy without any conditions listed below.*

Are you physically active?.....No ☐ | Yes ☐_____

How often do you exercise? _____

Do you now have or have you ever had: If yes, please specify

Constitutional (fatigue, poor sleep, low energy)?.....No ☐ | Yes ☐_____

Neurologic problems (seizures, headaches, weakness, paralysis)?.....No ☐ | Yes ☐_____

Psychiatric problems? Depression? Mania? Bipolar?.....No ☐ | Yes ☐_____

Head/Ear/Eyes/Nose/Throat Problems?.....No ☐ | Yes ☐_____

Thyroid problems or glandular problems?.....No ☐ | Yes ☐_____

Cardiac (heart) problems? Palpitations? Chest Pain? Irregular Beat?.....No ☐ | Yes ☐_____

Lung problems? Asthma? Short of Breath? COVID 19?.....No ☐ | Yes ☐_____

Breast problems? Mass? Lumpiness? Discharge? Pain?.....No ☐ | Yes ☐_____

Gastrointestinal problems (gas, reflux, irritable bowel)?.....No ☐ | Yes ☐_____

Kidney or bladder disease? Stones? Infections? Blood in urine?.....No ☐ | Yes ☐_____

Liver problems, such as hepatitis?.....No ☐ | Yes ☐_____

Hematologic problems such as bleeding or anemia?.....No ☐ | Yes ☐_____

Diabetes (insulin dependent/oral medication) or low sugar?.....No ☐ | Yes ☐_____

Musculoskeletal (bones, joints, muscles) problems?.....No ☐ | Yes ☐_____

Circulation problems (varicose veins, thrombosis, blood clots)?.....No ☐ | Yes ☐_____

Cancer or Pre-Cancerous Conditions?.....No ☐ | Yes ☐_____

High blood pressure/Low blood pressure/Fainting spells?.....No ☐ | Yes ☐_____

Hernias in the abdomen?.....No ☐ | Yes ☐_____

Skin disorders (keloid, melasma, acne, rash, cancers).....No ☐ | Yes ☐_____

Hair problem (hair thinning, balding, scarring)?.....No ☐ | Yes ☐_____

Gynecologic (fibroid, ovarian cyst, painful period)?.....No ☐ | Yes ☐_____

Vaginal looseness, difficulty orgasm, pain, decreased drive.....No ☐ | Yes ☐_____

Urinary problems (if yes, fill out section on the next page)?.....No ☐ | Yes ☐_____

STD (HIV, Gonorrhea, Chlamydia, Hepatitis, Syphilis, Warts) .....No ☐ | Yes ☐_____

Genital herpes?.....No ☐ | Yes ☐_____

Oral herpes or cold sores?.....No ☐ | Yes ☐_____

Poor wound healing or frequent infections?.....No ☐ | Yes ☐_____

Any metal implants, such as metal IUD, metal plates or rods?.....No ☐ | Yes ☐_____

Problems with anesthesia (nausea, anxiety, allergic reaction).....No ☐ | Yes ☐_____

Other: _____

Pregnancy History (if applicable):

☐ Skip this section, this does not apply to me.

Are you pregnant? No ☐ | Yes ☐

If you're planning to conceive, anticipated time (in months): _____

Are you nursing? No ☐ | Yes ☐

Date	Weeks	Weight	Sex	Type of Delivery Vaginal/ C-Section	Place of Delivery	Complications

Gynecologic History (if applicable):

☐ *Skip this section, this does not apply to me.*

Do you have menstrual periods? No ☐ | Yes ☐

Is your uterus still present? No ☐ | Yes ☐

Date of last menstrual period: _____

Date of last PAP smear? _____

Any history of abnormal PAP smear or HPV infection? No ☐ | Yes ☐ Specify:_____

Date of last mammogram? _____ Normal ☐ | Abnormal ☐ Specify: _____

Type of birth control method used : _____ No ☐ | Yes ☐ Specify: _____

Current or previous hormone use: _____ No ☐ | Yes ☐ Specify: _____

Urinary Symptoms (if applicable):

☐ *Skip this section, I have no bladder or urinary problems.*

Do you leak urine (incontinence)? No ☐ | Yes ☐ _____

Is it caused by coughing, laughing, sneezing, running, sports, etc? No ☐ | Yes ☐ _____

Is the amount of urine you usually leak: Large ☐ Average ☐ Small ☐

Do you have to wear pads or pantiliners for this type of incontinence? No ☐ | Yes ☐ _____

Are you bothered by a strong sense of urgency to void? No ☐ | Yes ☐ _____

Can you overcome the sensation of urgency to void? No ☐ | Yes ☐ _____

Do you sometimes not make it to the bathroom in time? No ☐ | Yes ☐ _____

Do you lose urine during intercourse? No ☐ | Yes ☐ _____

Do you lose urine without any activity or urgency? No ☐ | Yes ☐ _____

Do you have pain or burning with urination? No ☐ | Yes ☐ _____

Are you bothered by your incontinence? No ☐ | Yes ☐ _____

Do you have reduced self-esteem, depression, or frustration due to this issue? No ☐ | Yes ☐ _____

Have you had evaluation for incontinence? No ☐ | Yes ☐ List:_____

Are you on any prescription medication for incontinence or urgency? No ☐ | Yes ☐ _____

Have you underwent any surgeries or procedures for incontinence? No ☐ | Yes ☐ Procedure:_____Date_____

Do you have trouble holding your flatus or stool? No ☐ | Yes ☐ _____

Previous Surgeries or Hospitalizations? Please list with dates

_____

_____

_____

Prescription or OTC Medications / Supplements (include pellets or IV)

Medication and dosage	Last taken (days):
_____	_____
_____	_____
_____	_____

Have you ever taken any **GOLD** containing medication? No ☐ | Yes ☐_____

Are you on any type of blood thinners (e.g. Aspirin, Warfarin, Fish Oil, etc.)? No ☐ | Yes ☐_____

Topical Medications

☐ Retin A ☐ Renova ☐ Tazorac ☐ Refissa ☐ Differen ☐ Other: (list)_____

Allergies

Medication	Reaction
_____	_____
_____	_____
_____	_____

Latex allergy? No ☐ | Yes ☐ Iodine allergy? No ☐ | Yes ☐

Social History:

Are you sexually active? No ☐ | Yes ☐

Sexual Preference ☐ Male ☐ Female ☐ Both ☐ Neither

Marital Status ☐ Married ☐ Single ☐ Divorced ☐ Widowed

Education (highest level) _____

Do you smoke? No ☐ | Yes ☐ If yes, how many years? Last use: _____

Do you drink alcohol? No ☐ | Yes ☐ Amount and Type: Last time you drank: _____

Do you use recreational drugs? No ☐ | Yes ☐ Amount and Type: Last use: _____

Have you ever been abused? No ☐ | Yes ☐ Specify:_____

Ethnicity Background: _____

Family History: (please check all that applies):

☐ Adopted	☐ Diabetes	☐ Pelvic Organ Prolapse
☐ Alzheimer or Dementia	☐ Endometriosis	☐ Psychiatric Disorders
☐ Arthritis	☐ Fibroids	☐ Skin Disease
☐ Autoimmune Disorders	☐ Heart Disease	☐ Stroke
☐ Cancer, specify:_____	☐ Melanoma	☐ Others:

*I hereby certify that, to the best of my knowledge, the provided information is true and accurate.

Patient Signature: _____ **Date:**_____ **Time:** _____

Reviewed By: _____ **Signature:**_____ **Date/Time:**_____

New Patient
Physical Examination

Height (in)	Weight (lbs)	BMI	Skin Type:
			I ☐/ II ☐ / III ☐ / IV ☐ / V ☐ / VI ☐
Blood Pressure	Pulse	RR	Temp (F)

	Normal	Abnormal	
Appearance:	☐	☐	_____
HEENT:	☐	☐	_____
Face:	☐	☐	_____
Heart:	☐	☐	_____
Lungs:	☐	☐	_____
Breast/Chest:	☐	☐	_____
Abdomen:	☐	☐	_____
Extremities:	☐	☐	_____
Skin:	☐	☐	_____
Other:	_____		

Gynecologic Exam:

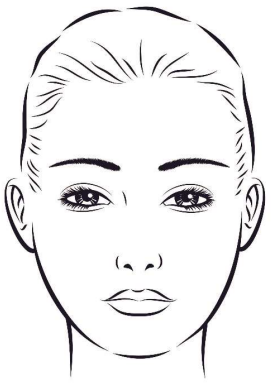
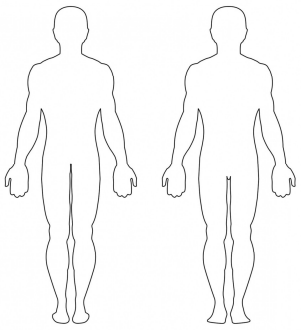
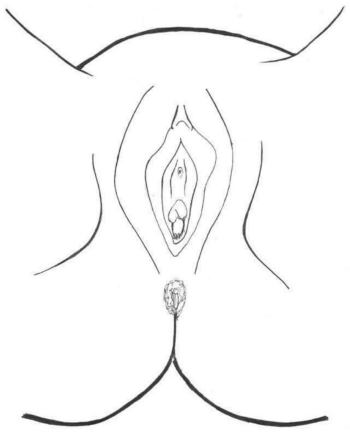
Introitus:	☐ Normal	☐ Virginal	☐ Stenotic	☐ Parous				
Estrogenization:	☐ Normal	☐ Atrophic						
Neurologic:								
Clitoral Reflex	☐ Normal	☐ Decreased	☐ Absent					
Anal Wink:	☐ Normal	☐ Decreased	☐ Absent					
Perineal Body:	☐ Normal	☐ Shortened	☐ Absent					
Vulvar/Perineal/Vaginal:	☐ Normal	☐ Labial Enlargement	☐ Labial Asymmetry					
Vaginal Pelvic Floor Muscle Tone:	☐ Good	☐ Fair	☐ Poor					
Squeeze test:	☐ Good	☐ Fair	☐ Poor					
Vaginal Circumference(# digits)	☐ 1 FB	☐ 2 FB	☐ 3 FB	☐ 4 FB				
Cystocele Stage:	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4			
(lateral / central / combined)								
Rectocele (distal / proximal) Stage:	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4			
Enterocele: Stage:	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4			
Vaginal cuff prolapse: Stage:	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4			
Tenderness on palpation	☐ none	☐ bladder	☐ forchete	☐ cervix				
	☐ cuff	☐ urethra	☐ perineal	☐ adnexa				
	☐ uterus							

Patient Name: _____ Date of Birth:_____

Uterus:	☐ present	☐ absent		
Size:	☐ normal	☐ enlarged	☐ atrophic	
Prolapse: Stage:	☐ 0	☐ 1 ☐ 2	☐ 3 ☐ 4	
Right Adnexa:	☐ normal	☐ mass	☐ TTP	
Left Adnexa:	☐ normal	☐ mass	☐ TTP	
Rectal Tone:	☐ normal	☐ abnormal		
Hemorrhoids:	☐ none	☐ external skin tag	☐ external	☐ internal

Cosmetic Gynecologic Assessment:

☐ Vaginal Laxity _____
☐ Enlarged / Loose ☐ Labia Minora ☐ Labia Majora
☐ Labia Minora Asymmetry _____
☐ Excess Clitoral Hood _____
☐ Labia Majora ☐ Bulging ☐ Deflated
☐ Excess Perineal Tissue
☐ Other _____

	Drawings/Measurements:	
Face Diagram	Body Diagram	Vaginal Diagram
	Front Back 	

Patient Name: _____ Date of Birth:_____

IMPRESSION:
_____ _____ _____ _____ _____
PLAN & RECOMMENDATIONS:
_____ _____ _____ _____ _____ _____ _____

DISCUSSIONS:

- ☐ Risks/Benefits/Options of Procedure
- ☐ Meet with Finance/Business Office
- ☐ Meet with Scheduler
- ☐ Read Educational Materials
- ☐ Review Website Videos and Articles
- ☐ Review Pre and Post Op Instructions
- ☐ Discuss/Schedule Pre & Post Op Photos
- ☐ Skin Care and Sun Exposure

Physician Name: _____ Signature:_____

Date: _____ Time: _____