Cosmetic Acupuncture for Facial Rejuvenation Registration

Your questionnaire provides valuable information which helps us understand the underlying causes of your health concerns. All questions contained in this history form are strictly confidential and will become part of your medical record on file.

PATIENT NAME: _____

TELEPHONE: _____

EMAIL: _____

ADDRESS: _____
_____
_____

1. Please check any of the following which are of most concern to you:

- Bags / swelling under eyes
- Sagging face
- Wrinkles
  - Nasolabial (nose to mouth)
  - Eyes (crow's feet)
  - Lips
  - Other: _____
- Vertical creases / furrows
- Droopy eyelids
- Double chin
- Oily skin
- Dry skin
- Lusterless skin
- Acne
- Acne scarring
- Rosacea
- Sun damage
- Large pores
- Broken capillaries
- Other skin conditions / issues:
  _____
  _____

2. What improvements would you like to see?

_____
_____
_____
_____

3. Please describe any skin sensitivities or allergies:

_____
_____
_____

4. Do you wear makeup daily? ❑Yes ❑No

Do you wear sunscreen daily? ❑Yes ❑No

5. Please describe your current skin care regimen and products that you use. (Toner, astringent, exfoliation, masks, etc.):

_____
_____
_____

6. Do you go to tanning booths? ❑Yes ❑No

Do you participate in vigorous aerobic activity or sport? ❑Yes ❑No

7. Do you get facial waxing / electrolysis / or use depilatories?
❑Yes, wait approximately 5 days between treatments ❑No

8. Please check all procedures you have had or are currently undergoing.

- o Botox injections
- o Collagen injections
- o Restalyne
- o Silicon injections
- o Microdermabrasion
- o Chemical peels
- o Laser procedures
- o Blepharoplasty
- o Brow or coronal lift
- o Rhytidectomy (face lift)
- o Other:

_____
_____

9. Additional Health History, check all that apply:

- o Epilepsy/Convulsions/Seizure
- o Stroke
- o Ear Problems/Infections
- o Sinus Problems
- o Difficulty Breathing
- o Headache
- o Frequent/recurring hives/rashes
- o Vertigo
- o Loss of bowel/bladder control
- o Fears/Phobias
- o HIV
- o Hepatitis
- o High Blood Pressure
- o Pain Over Heart
- o Palpitation/Ireg Heart Beat
- o Cancer

10. Please list any medications that you are currently taking:

_____
_____
_____
_____

11. Current Cosmetic Physician: _____

Primary Care Physician: _____

Before treatment, wash face and neck and remove all makeup and/or lotions.