DESERT MED AESTHETIC
DORIANA COSGROVE, MD

Date: _____

Name_____ **Birth Date:** _____ Sex: M F

Marital Status: S M W D DP If married, spouse's name: _____

Local Address: _____
Street *City* *State, Zip Code*

Phone No: (_____) _____ (*please circle*) cell home work

***May we leave messages concerning your treatments on the voicemail associated with this number? Y/N**

Preferred method of communication: Phone _____ Text _____ Email _____

Email Address: _____ Referred by: _____

Emergency Contact:

Name: _____ Relationship: _____

Phone No: (_____) _____ Club Affiliation: _____

BRIEF MEDICAL HISTORY QUESTIONNAIRE:

1.	Are you now or have you been in the past 2 years under the care of a physician?	**Y**	**/**	**N**
2.	Are you taking any medication under an M.D.'s order? If yes please list:_____	**Y**	**/**	**N**
3.	Are you taking any aspirin, ibuprofen, or any other blood thinning medications? If yes please list:_____	**Y**	**/**	**N**
4.	Do you have any allergies or are you sensitive to any drug or medication? If yes please list:_____	**Y**	**/**	**N**
5.	Have you ever had an unfavorable reaction from previous anesthetics or treatment? If yes please list:	**Y**	**/**	**N**
6.	Are you currently using any Retin A or Tretinoin products?	**Y**	**/**	**N**
7.	Any history of Cold Sores?	**Y**	**/**	**N**

Please circle any that apply to you:

Heart Trouble/Murmur	Glaucoma	Anemia	Liver Disease	Joint Replacement	AIDS/HIV	Kidney Disease
High Blood Pressure	Hepatitis	Stroke	Thyroid Disease	Chest Pain	Diabetes	Tuberculosis

Not Listed: _____ Ethnicity: _____

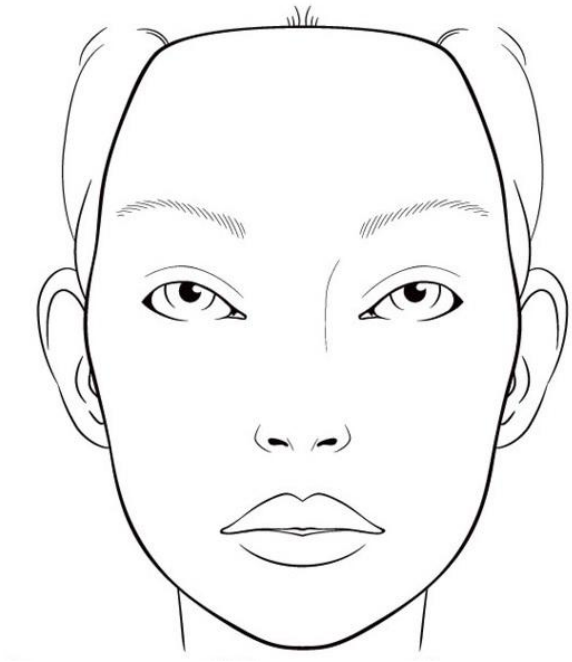
Female Patient's:

1.	Are you pregnant?	**Y**	**/**	**N**

2.	Are you Nursing a baby?	**Y**	**/**	**N**

Health Interests:

Our goal is to respond to all of our patients' needs and to provide the highest quality of care. In order to provide the information on services and products you desire on the health and appearance of your skin, we invite you to complete the following questionnaire: Simply check mark all the things that apply and mark the problem areas on the face map.



Brown spots on face	
Lines around my eyes	
Sagging neckline	
Scarring	
Lines between my eyes	
Crease near nose/mouth	
Lines on my forehead	
Unwanted veins	
Red blotchy skin	
Wrinkles	
Frown lines	
Lines under my eyes	
Thin face, no cheeks	
Looking tired	
Thin lips	
Double chin	
Unwanted fat (Body)	

Please list the name of the product you are currently using in each step of your current skin care regimen:

Morning	**Night**

I AUTHORIZE Dr. Cosgrove to examine and provide Medical/Surgical Treatment. I will not record, in anyway, anything which occurs in the office of Dr. Cosgrove without prior written consent of Dr. Cosgrove.
I AGREE that I am responsible for the professional services rendered by Desert Med Aesthetics, Doriana A. Cosgrove, M.D. or her associates, despite any insurance coverage.

Signature: _____ Date: _____

FOR OFFICE USE ONLY: Reason for Consultation: _____ Previous treatments:	Physician Recommendations:

Coord: _____ Photos: _____ Consent: _____ Aesthetician: _____ CS: _____ RN: _____