THE NADERI CENTER 297 Herndon Pkwy, Suite 101, Herndon, VA 20170 703.481.0002
5454 Wisconsin Ave, Suite 1655, Chevy Chase, MD 20815 301.222.2020

Patient Name:	
What procedure(s) are you considering?	

DO YOU **NOW** OR HAVE YOU **EVER** HAD…….. (You must circle an answer for each individual item)

Heart Trouble	Yes	No		Any Hospitalization or Previous Surgery	Yes	No
Stroke	Yes	No		Any Eye Problems	Yes	No
Blood Pressure Abnormalities	Yes	No		Hepatitis or Cirrhosis of the Liver	Yes	No
Abnormal EKG	Yes	No		Easy scarring	Yes	No
Rheumatic Fever	Yes	No		Alcoholism or Drug Dependency	Yes	No
Shortness of Breath	Yes	No		Ulcers or G.I Problems	Yes	No
Chest Pain	Yes	No		Constipation	Yes	No
Asthma or Lung Disease	Yes	No		Vomiting Blood	Yes	No
Tuberculosis	Yes	No		Hemorrhoids	Yes	No
Coughing or Spitting Blood	Yes	No		Goiter or Thyroid Disorders	Yes	No
Hay Fever or Major Allergies	Yes	No		Diabetes	Yes	No
History of Anesthesia problems	Yes	No		Skin Disorders or rashes	Yes	No
Numbness or Paralysis	Yes	No		Arthritis	Yes	No
Anxiety or Nervous Breakdown	Yes	No		Fracture of Neck or Spine	Yes	No
Neurologic Disorder	Yes	No		Bleeding Tendency or Disorder	Yes	No
Insomnia	Yes	No		Abnormal Bleeding after Tooth Extraction	Yes	No
Recreational Drug Use	Yes	No		Airway Obstruction (Nasal)	Yes	No
Self-Destructive Tendencies	Yes	No		Previous Blood Transfusion	Yes	No
Psychiatric Hospitalization or Care	Yes	No		Seizures or convulsions or fainting spells	Yes	No
Kidney Disease	Yes	No		Black outs	Yes	No
Depression	Yes	No		Dentures, bridges, capped teeth or crowns	Yes	No
Positive blood test for: HIV, AIDS, Hepatitis	Yes	No		Loose teeth	Yes	No
Missed or irregular last menstrual period	Yes	No		Previous Cosmetic Dental Work	Yes	No
Family history of cancer, heart trouble, stroke	Yes	No		Any family members with bleeding problems	Yes	No
Easy Bruising or bleeding	Yes	No		Any family members with anesthesia problems	Yes	No
!!!Any drug or medication ALLERGIES?	**YES**	**NO**		Pregnant or Breast Feeding	Yes	No

If you answered "yes" to any of the above, please explain fully below:

_____

_____

_____

If you are considering breast or body surgery please specify recent **HEIGHT** _____ **WEIGHT**_____lbs.

1. **Please list all present medications**, including **Accutane**, **birth control pills**, hormones, and vitamins, **herbal** supplements, diuretics, **weight loss drugs, energy drinks**. Also, **topical** skincare medications or creams including tretinoin (Retin-A), Differin, Metro-gel, etc. **Include over-the-counter medications.**
2. _____

_____

_____

3. Have you ever had an adverse reactions to any skin related procedures or cosmetics? ❒ Yes ❒ No
   Name of product/procedure and reaction: _____
   _____
4. Do you have a history of cold sores or fever blisters? ❒ Yes ❒ No Date of last outbreak?_____

5. What is your ethnic background (for purposes of aesthetic treatments)?_____

6. In response to sun exposure, do you typically tan or burn? _____

   Would you consider yourself to have a tan at this point in time? ❒ Yes ❒ No

7. Do you have cocktails regularly, or consume regular amounts of alcoholic beverages, including beer, wine, or other alcohol?

   ❒ Yes ❒ No If so, how much? _____

8. Do you smoke or use any **Nicotine** containing products (i.e. gum, patch, etc)? ❒ Yes ❒ No
   If so, how much? _____ For how long? _____

9. Are you pregnant or breastfeeding? ❒ Yes ❒ No

10. Are you actively trying to become pregnant currently or in near future? ❒ Yes ❒ No

11. When was you last normal menstrual period? _____

IF YOU ARE TO BECOME PREGNANT, BE SURE TO LET OUR OFFICE KNOW IMMEDIATELY. SOME PROCEDURES OR PRODUCTS ARE CONTRAINDICATED WITH PREGNANCY OR BREAST FEEDING AND MAY BE HARMFUL TO YOUR CHILD! (i.e. Retin-A, Hydroquinone, etc…)

12. Primary Care Physician_____ Phone Number_____

13. Have you ever been under psychiatric care? ❒ Yes ❒ No When? _____
    Why? _____

    _____

    _____

14. Please list all hospitalizations, surgeries and procedures , including cosmetic: (include where, when and why for each):

    _____

    _____

    _____

15. What are your expectations for your appointments with us?_____

    _____

16. Do you understand that there is no such thing as "perfection" and that the goal of any cosmetic procedures is "improvement?" ❒ Yes ❒ No

17. Do you understand that there are risks associated with all procedures such as infection, allergic reaction, scarring, asymmetry, need for further procedures, etc? ❒ Yes ❒ No

By signing below, I agreee that the above information is complete and accurate to the best of my knowledge.

Signature: _____ Date: _____
(If under 18 then signature and name of parent or guardian)

Print Name:_____