AESTHETIC HISTORY AND PHYSICAL **Date: _____**

Patient Name_____ **Medical Record #** _____
Age_____ **Date of Birth** _____ **Last Menses (1st Day)**_____
Pregnancies_____ **Births**____**(Vaginal** ____**Caesarean**____**)** **Miscarriages**____ **Abortions**___
Address: _____
_____
Phone (Home) _____ **Allergies**: ☐None (**NKA**)
Phone (Work) _____ ☐Yes _____
Phone (Cell) _____ _____
Phone (Fax) _____ _____
Email _____ _____

How did you hear about us? Referred by: _____

CHIEF COMPLAINT (Why you want to see the doctor today?)
_____
_____
_____
_____
_____
_____

INTERESTED IN AESTHETIC LABIAL AND/OR VAGINAL SURGERY

_____ I want aesthetic vaginal surgery
_____ My labia are larger/looser than what I want
_____ I do not like the way my labia looks
_____ My labia rub, tug, and pull on my clothing
_____ I am unable to wear type of clothing I want
_____ I have had unflattering comments about my genital region
_____ I have had difficult births
_____ My vagina feels too loose inside
_____ I have decreased sensations
_____ I feel pelvic heaviness/pressure
_____ Sex is uncomfortable/unpleasant
_____ I rely on my appearance at work
_____ I am interested in G-Spot treatments

INTERESTED IN NONE SURGICAL TREATMENTS

☐ To tighten the labia majora
☐ To tighten the vagina
☐ To treat a leaky bladder
☐ To reduce urinary urgency and frequency
☐ To improve vulvar and vaginal moisture
☐ To improve sensitivity of tissues
☐ To improve or achieve orgasms
☐ Reduce painful intercourse

INTERESTED IN AESTHETIC LASERS/IPL/RADIOFREQUENCY TREATMENTS

☐ I want Vulvar Lightening
☐ I want to remove brown spots/sun damage
☐ I want to remove red blood vessels
☐ I want Fotofacial/Fraxel
☐ I want Hair or/and Vein reduction
☐ I want Skin Tightening
☐ I want Botox/Skin Fillers
☐ I want Stretch Marks/Scar Reduction
☐ I want Collagen/Vitamin C Facials
☐ I want info on Skin Care Products

PAST MEDICAL HISTORY/REVIEW OF SYSTEMS: Circle all that apply, Give details
☐ **Skip this section. I am completely healthy without any conditions mentioned below.**

Are you physically active? Yes No
What type of exercise?_____
Do you now have or have you ever had:
Neurologic problems(seizures, headaches, weakness, paralysis) ? Yes No _____
Psychiatric problems? Depression? Mania? Bipolar? Yes No _____
Head/Ear/Eyes/Nose/Throat Problems? Yes No _____
Thyroid problems or glandular problems? Yes No _____
Cardiac (heart) problems? Palpitations? Chest Pain? Irregular Beat? Yes No _____
Lung Problems? Asthma? Short of Breath? Yes No _____
Breast Problem? Mass? Lumpiness? Discharge? Pain? Yes No _____
Gastrointestinal (stomach) problems (gas, reflux, irritable bowel)? Yes No _____
Kidney or bladder disease? Stones? Infections? Blood in urine? Yes No _____
Liver problems such as hepatitis? Yes No _____
Hematologic problems such as bleeding or anemia? Yes No _____
Diabetes (insulin dependent/oral medication) or low sugar? Yes No _____
Musculoskeletal (bones, joints, muscles) problems? Yes No _____
Circulation problems (varicose veins, thrombosis, blood clots)? Yes No_____
Cancer or Pre Cancerous Conditions Yes No _____
High Blood Pressure or Low Blood Pressure/Fainting Spells Yes No _____
Hernias in the abdomen? Yes No _____
Problems with anesthesia, nausea, anxiety reaction? Yes No_____
STD (HIV, Gonorrhea, Chlamydia, Hepatitis, Syphilis, Warts) Yes No _____
OtherProblems_____
_____
_____

PAST SURGERIES OR PROCEDURES OR HOSPITALIZATIONS
☐**NONE**
Please list with date:
_____
_____
_____
_____

FAMILY HISTORY: (Write which has occurred in any blood relative and write relationship to you):
____ None significant
____ Family _____
_____

SOCIAL HISTORY:
Marital status: S M W D

Education:_____

Occupation: ☐Not Working ☐Working Where Working _____
What Occupation _____

Tobacco use: No Yes Caffeine use: No Yes
Alcohol use: No Yes Other Drugs No Yes
Abuse No Yes Describe _____

MEDICATIONS:
☐NONE ☐SEE ATTACHED LIST
Please list all current medications and dosages
_____
_____
_____
_____

EXAMINATION:
Constitutional: Ht_____ Wt_____ BMI_____

Temp_____BP _____ Pulse _____ Respiration _____

	Normal	**Abnormal**
Appearance:	[ ]	[ ]
HEENT:	[ ]	[ ]
Heart:	[ ]	[ ]
Lungs:	[ ]	[ ]
Breast/Chest:	[ ]	[ ]
Abdomen:	[ ]	[ ]
Extremities:	[ ]	[ ]
Skin	[ ]	[ ]
Lymph Nodes	[ ]	[ ]
Hernias	[ ]	[ ]
Pelvic:	[ ]	[ ]

Other_____
_____
_____
_____

Drawings/Measurements:

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

FOLLOW UP ____**Days** ____**Weeks** ____**Months** ____**Year/s**

PATIENT SIGNATURE _____

DOCTOR SIGNATURE _____

DATE _____