Arizona OCULOPLASTIC SPECIALISTS

Ali Ghafouri, MD, FACS
*Ophthalmic Plastic and Reconstructive Surgery*
*Facial Cosmetic Surgery*

Name:_____DOB:_____Age:_____
Phone:_____ Email:_____

Allergies:_____

**About You:**

What is your hereditary background? (circle all that apply) Nordic/ Scandinavian/ Irish/ English/ Asian/ Mediterranean/ Hispanic/ Native American/ Middle Eastern/ African American/ Other_____
Natural eye color:_____
Natural hair color:_____
Do you consider your skin (circle all that apply): Sensitive/ Resilient/ Unsure
Describe your skin (circle all that apply): Normal/ Dry/ T-Zone/ Combination/ Thick/ Thin/ Saggy/ Firm/ Oily/ Acne/ Comedones/ Blackheads/ Milia/ Cysts/ Breakouts/ Acne-scarred/ Large Pores/ Small Pores/ Rosacea/ Eczema/ Freckled/ Sun Damaged/ Melasma/ Hyperpigmentation/ Hypopigmentation/ Uneven/ Blotchy/ Mature/ Wrinkled/ Psoriasis/ Dehydrated/ Asphyxiated/ Broken Surface Capillaries
What are some changes you would most like to see in your skin?

**Lifestyle:**

Do you wear contact lenses?_____
Do you currently have a sunburn/windburn/red face? Why?_____
Are you in the habit of going to tanning booths? (If within past 14 days, decline treatment. This practice should be discontinued due to risk of skin cancer and signs of aging)_____
Do you participate in vigorous aerobic activity or sports?_____
Do you smoke or use Tabaco products?_____
What kind of work do you do?_____
On average, how many hours per week do you spend outdoors?_____

**Medical/Treatment History**

Allergies to: Lidocaine/ Hydrocortisone/ Hydroquinone
Do you currently use depilatories or wax?(Discontinue use for five days pre and post treatment)_____
In the last 14 days have you had a chemical peel or any type of procedure with a medical device?_____
What type of procedure?_____
Have you recently had laser resurfacing or facial surgery?_____
When?_____

9431 E. Ironwood Square Drive | Scottsdale, AZ 85258
480-905-1010 | 480-905-6988 fax | www.eyelidsurgeries.com

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Are you currently taking any medications, topical or otherwise?(Tretinoin/Retin-A/Renova/Differin/Tozorac/Avage/EpiDuo/Ziana)_____
Strength and Longevity:_____
Have you ever undergone Accutane therapy?_____
Do you develop cold sores/ fever blister?_____ Last breakout_____
Have you ever used any other products that caused a bad reaction?_____

Circle any of the following you have or have had in the past:
Myasthenia Gravis Hepatitis Eye Disease/vision problems Autoimmune Disease Numbness Epilepsy Muscle Weakness Multiple Sclerosis Amyotrophic Lateral Sclerosis (ALS) Parkinson's Disease Diabetes Neurological Disorders Lambert-Eaton Syndrome Bleeding Disorder Keloid Scars Thyroid Disease Hormone Therapy Herpes Heart Disease Endocrine Disorder Shingles

Other_____

Previous hospitalizations/surgeries (in last 3 years)_____
_____

Have you had plastic surgery to the face or neck?_____Date_____
Past Botox/similiar?_____Area_____Last treatment date_____
Were you happy with the results?_____If not, why?_____
Do you have trouble with droopy eyelids when tired?_____
Past Dermal Fillers?_____Area_____Last treatment date_____
Were you happy with the results?_____If not, why?_____

I understand that an antiviral medication is recommended if I desire a procedure to the lips and have ANY history of cold sores. **I understand the information on this form is essential to determine my medical and cosmetic needs and the safe provision of treatment. I certify that I will advise the office of any changes to my medical health/history.** I acknowledge that my answers have been recorded truthfully and I will not hold any staff member responsible for any errors or omissions that I have made in the completion of this form. I further understand that payment for any cosmetic service/product is expected in full at the time of service.

Client Signature_____Date_____

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