



Sirish Maddali, M.D.
Aesthetic Patient Questionnaire

Date: _____

First Name: _____ Middle Name: _____ Last name: _____

Marital Status: _____ M F

Date of Birth: _____ SSN: _____ - _____ - _____

Address: _____ City: _____

State: _____ Zip: _____ E-mail: _____

Home phone: _____ Cell phone: _____

Office phone: _____

Preferred method of contact: E-mail Home phone Cell phone Office phone

Employer: _____ Occupation: _____

Employer Address & Phone #: _____

Whom may we contact in an emergency?

Name: _____ Relationship: _____

Telephone: _____ Cell: _____

Address: _____

Referral Source:

I was referred to Dr. Maddali by (name and relation): _____

I saw/learned about Dr. Maddali in (choose all that apply):

Web: www.fraxel.com www.silkpeel.com www.drsmaddali.com www.yelp.com

www.citysearch.com www.botox.com www.Restylane.com

Other website: _____

Other: Article/News: _____ Seminar: _____

Patient Name: _____

Personal Goals:

The reason for my consultation today is: _____

I have the following concerns/interests:

Aging appearance of my:

- Skin
- Face
- Eyes
- Lips and mouth
- Neck
- Furrowed brow
- Sad, baggy, puffy eyelids
- Heavy Jowls
- Double chin
- Facial folds and creases
- Fine lines and wrinkles
- Sun damage
- Skin tone
- Loss of facial fullness

Breast:

- Size
- Shape
- Position, sagging
- Symmetry between my breasts

Facial appearance/proportion:

- Eyes
- Nose
- Ears
- Cheeks
- Lips
- Jaw
- Chin

Body:

- Arms
- Back
- Breast
- Upper Abdomen
- Lower Abdomen
- Buttocks
- Hips
- Inner Thighs
- Outer Thighs
- Legs
- Excess Fat Deposits
- Exaggerated curves
- Lack of defined curves

Other:

- Facial/Body irregular Veins
- Irregular scars
- Moles, lesions, or other growths
- Excess body hair
- Hair Loss

*****Skin Type (all patients)***:**

- Always burns, never tans
- Usually burns, rarely tans
- Sometimes burns, tans gradually
- Rarely burns, tans easily
- Very rarely burns, tans very easily
- Never burns, tans very easily

I have had the following treatments (please list the exact type and date of last treatment or series of treatments):

Aesthetic or cosmetic surgery (list type and date): _____

Botox® or similar treatment (botulinum type/regions treated/frequency/date of last treatment): _____

Injected or implanted fillers (filler type/regions treated/date of last treatment): _____

Skin resurfacing (chemical peel, dermabrasion, laser resurfacing): _____

Light/Energy-based treatments (i.e. IPL, Thermage®, Laser) (date/reason): _____

I use the following daily skincare (prescriptive, physician-based or over the counter): _____

Patient Name: _____

General Health History:

MEDICATIONS (& herbals): _____

ALLERGIES: _____

****Do you take oral retinoids or Accutane?** _____

SURGERIES: _____

I am presently under a **DOCTOR'S CARE** for the following conditions:

- | | |
|---|---|
| <input type="checkbox"/> HEART PROBLEMS | <input type="checkbox"/> DIABETES |
| <input type="checkbox"/> HIGH BLOOD PRESSURE | <input type="checkbox"/> CANCER |
| <input type="checkbox"/> LUNG DISEASE (EMPHYSEMA, COPD, ASTHMA) | <input type="checkbox"/> PSYCHIATRIC DISORDER |
| <input type="checkbox"/> SEIZURES OR OTHER NEUROLOGICAL DISORDERS | <input type="checkbox"/> BLEEDING PROBLEMS |
| <input type="checkbox"/> AIDS or HIV | <input type="checkbox"/> ARTHRITIS |
| <input type="checkbox"/> HEPATITIS | <input type="checkbox"/> KIDNEY DISEASE |
| <input type="checkbox"/> COLD SORES | <input type="checkbox"/> THYROID PROBLEMS |
| <input type="checkbox"/> MITRAL VALVE PROLAPSE | <input type="checkbox"/> OTHER: _____ |

Primary Care Physician: _____ Phone #: _____

Address: _____

I would describe my **PRESENT STATE OF HEALTH** as: _____

Have you ever or do you now **SMOKE?** YES NO. If YES, when and how much: _____

How much alcohol do you drink weekly? _____

I attest the above history is completed to the best of my knowledge and understand and accept that my failure to disclose any of the above information can adversely affect a prescribed course of treatment to meet my goals, my safety, or the outcome of any treatment I elect to undergo with Dr. Maddali or any member of his staff.

Patient signature: _____

Date: _____