



Center for
Cosmetic &
Laser Surgery

Dr. Bryan W. Rubach, M.D.

Dr. Joseph A. Franco, M.D.

Name: _____ Date: _____ Age: _____

Medical History	Yes	No	Comments:
Hypertension	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cutaneous Malignancy	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hypertrophic Scarring (Keloid)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Aspirin Use	<input type="checkbox"/>	<input type="checkbox"/>	_____
Tobacco Use	<input type="checkbox"/>	<input type="checkbox"/>	_____
Accutane Treatment	<input type="checkbox"/>	<input type="checkbox"/>	_____
Previous Aesthetic Surgery	<input type="checkbox"/>	<input type="checkbox"/>	_____

Please list all medications you are currently taking (prescription, over the counter, or naturopathic):

Please list any known allergies to medications:

Please list all past surgeries:

Please indicate the services that you are interested in. Use the space provided to specify a particular area or concern:

- Botox Injections (Used to treat frown lines and crow's feet) _____
- Juvederm/Restylane/Collagen Injections _____
- Laser Resurfacing/Skin Rejuvenation _____
- Face Lift _____
- Neck Lift _____
- Brow Lift _____
- Eyelid Surgery _____
- Nasal Refinement Surgery _____
- Liposuction-Please indicate area(s): _____
- Ear Refinement surgery _____
- Lip Augmentation _____
- Breast Augmentation _____
- Abdominal Contouring _____
- Hair Removal _____
- Scar Revision _____
- Other-please specify _____