Kimberly Cockerham, MD
FACIAL AESTHETICS, LASERS & RECONSTRUCTIVE SURGERY
Central Valley Eye Medical Group Inc.

Name:___________________________________ Date:______________

Important Questions That May Affect Your Treatment Plan

		Yes / No
1.	How would you describe your skin:	
	a) Sensitive	___ ___
	b) Prone to brown spots (hyperpigmentation)	___ ___
	c) Easily sunburned	___ ___
2.	Do you have problems healing?	___ ___
3.	Do you have any "bad" scars or keloids (raised, tender, red, hyperpigmented)?	___ ___
4.	Do you have rosacea (redness, broken vessels and acne) of the cheeks and nose?	___ ___
5.	Do you have melisma (brown patches on your cheeks)?	___ ___
6.	Have you ever had a reaction to topical or injected lidocaine?	___ ___
7.	Do you have a fear of needles?	___ ___
8.	Have you ever fainted?	___ ___
9.	Do you have a history of skin cancer?	___ ___
10.	Do you have a history of breast, lung or other cancer?	___ ___
11.	Do you have a history of a thyroid abnormality?	___ ___
12.	Do you have an autoimmune disease like Lupus, Sjogren's or Sarcoidosis?	___ ___
13.	Do you have any other health issues or skin problems that concern you?	___ ___
14.	Do you have a history of cold sores?	___ ___
15.	Have you ever had herpes?	___ ___
16.	Do you have any neurologic problems like myasthenia gravis or muscle weakness?	___ ___

(Please circle all that apply)

Medications: Acutane Retin A Hydroquinone Aspirin/Motrin

Pain Medication **Supplements** (VIT C, E, Flax Seed, Fish Oil) Other:__________

Allergies to food or medicine: Penicillin Sulfa Iodine Latex___________