Cheryl M. Yokoyama, M.D.

Specializing in

Laser Resurfacing

Eyelid Surgery

Brow & Forehead Lifts

Skin Rejuvenation

Wrinkle Relaxation

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PATIENT CONSULTATION / HISTORY FORM

Dr. Yokoyama and her trained staff are committed to helping you meet your needs and personal goals. Thank you for taking time to fill this form out to help us better serve you.

Patient Name ______ Birthday / / Age ______
Primary Care Provider ______ Date of physical exam / /
Preferred Contact ❑ Cell Phone ❑ E-Mail ❑ Other: ______

My appearance concerns are:

- ❑ Wrinkles
- ❑ Droopy brows
- ❑ Frown lines
- ❑ Puffiness under eyes
- ❑ Sun-damaged skin /uneven skin texture
- ❑ Vertical lip lines
- ❑ Facial spider veins
- ❑ Other areas of concern ______

I am interested in knowing more about:

- ❑ Facial Rejuvenation
- ❑ Eyelid surgery
- ❑ Brow lift / Cheek lift
- ❑ Botox injections to soften wrinkles
- ❑ Obagi® skin care
- ❑ Hair Removal
- ❑ Other procedures of interest

______

Hair removal (last 6 weeks)	❑ Plucking	❑ Waxing	❑ Electrolysis
Tanning (last 6 weeks)	❑ Sun Exposure	❑ Tanning Products	❑ Tanning Bed
Previous Procedures	❑ Chemical Peels	❑ Microdermabrasion	❑ Laser / Light Treatments

Do you have tattoos / permanent make-up? ❑ Yes ❑ No If yes, where? ______

Social History: ❑ Married ❑ Divorced ❑ Single ❑ Widowed
Alcohol ❑ Yes ❑ No Smoker ❑ Yes ❑ No ppd ______

Medical History:

❑ Heart Trouble	❑ Asthma / Wheezing	❑ Skin Problems	❑ Arthritis
❑ Heart Murmur	❑ Bleeding Tendency	❑ Keloid Former	❑ Cold Sores
❑ High Blood Pressure	❑ TB Exposure / TB	❑ Thyroid Disorder	❑ Skin Cancer
❑ Scarlet / Rheumatic Fever	❑ Emphysema	❑ Varicose Veins or Phlebitis	❑ HIV Positive / AIDS
❑ Pace Maker	❑ Hay Fever	❑ Metal Implants	❑ Hepatitis:Type A, B
❑ Diabetes	❑ Sinus Infections	❑ Acid Reflux	❑ Other

Pregnant? ❑ Yes ❑ No Nursing? ❑ Yes ❑ No Contact Lenses? ❑ Yes ❑ No
Are there any other health concerns we should know about? ______

______

Allergies to Medications: ______

Current Medications (prescriptions and over-the-counter) Please specify the dosage (if known):
❑ Retin-A ❑ Accutane ❑ Aspirin / Blood Thinners ❑ Other ______

______

______

Hospitalizations / Surgeries (description and dates) ______

______

Have you had problems with anesthesia? ❑ Yes ❑ No

Signature ______ Today's Date ______