

**Office of Dr. Bradley Backhaus
Cosmetic Acupuncture for Facial Rejuvenation Registration**

Your questionnaire provides valuable information which helps us understand the underlying causes of your health concerns. All questions contained in this history form are strictly confidential and will become part of your medical record on file.

Patient Name _____ Date of Birth _____
Phone _____
Email _____
Address _____

1. Please check any of the following which are of most concern to you:

- | | |
|--|--|
| <input type="radio"/> Bags / swelling under eyes | <input type="radio"/> Lusterless skin |
| <input type="radio"/> Sagging face | <input type="radio"/> Acne |
| <input type="radio"/> Wrinkles | <input type="radio"/> Acne scarring |
| <input type="radio"/> Nasolabial (nose to mouth) | <input type="radio"/> Rosacea |
| <input type="radio"/> Eyes (crow's feet) | <input type="radio"/> Sun damage |
| <input type="radio"/> Lips | <input type="radio"/> Large pores |
| <input type="radio"/> Other: _____ | <input type="radio"/> Broken capillaries |
| <input type="radio"/> Vertical creases / furrows | <input type="radio"/> Other skin conditions / issues:
_____ |
| <input type="radio"/> Droopy eyelids | _____ |
| <input type="radio"/> Double chin | _____ |
| <input type="radio"/> Oily skin | _____ |
| <input type="radio"/> Dry skin | |

2. What improvements would you like to see?

3. Please describe any skin sensitivities or allergies:

4. Do you wear makeup daily? __Yes __No
Do you wear sunscreen daily? __Yes __No

5. Please describe your current skin care regimen and products that you use. (Toner, astringent, exfoliation, masks, etc.):

6. Do you go to tanning booths? __Yes __No
Do you participate in vigorous aerobic activity or sport? __Yes __No

7. Do you get facial waxing / electrolysis / or use depilatories? __Yes __No
If yes, wait approximately 5 days between treatments.

8. Please check all procedures you have had or are currently undergoing.

- | | |
|---|--|
| <input type="radio"/> Botox injections | <input type="radio"/> Blepharoplasty |
| <input type="radio"/> Collagen injections | <input type="radio"/> Brow or coronal lift |
| <input type="radio"/> Restalyne | <input type="radio"/> Rhytidectomy (face lift) |
| <input type="radio"/> Silicon injections | <input type="radio"/> Other: |
| <input type="radio"/> Microdermabrasion | _____ |
| <input type="radio"/> Chemical peels | _____ |
| <input type="radio"/> Laser procedures | _____ |

9. Additional Health History, check all that apply:

- | | |
|---|---|
| <input type="radio"/> Epilepsy/Convulsions/Seizure | <input type="radio"/> Loss of bowel/bladder control |
| <input type="radio"/> Stroke | <input type="radio"/> Fears/Phobias |
| <input type="radio"/> Ear Problems/Infections | <input type="radio"/> HIV |
| <input type="radio"/> Sinus Problems | <input type="radio"/> Hepatitis |
| <input type="radio"/> Difficulty Breathing | <input type="radio"/> High Blood Pressure |
| <input type="radio"/> Headache | <input type="radio"/> Pain Over Heart |
| <input type="radio"/> Frequent/recurring hives/rashes | <input type="radio"/> Palpitation/Ireg Heart Beat |
| <input type="radio"/> Vertigo | <input type="radio"/> Cancer |

10. Please list any medications that you are currently taking:

11. Current Cosmetic Physician: _____
Primary Care Physician: _____

***Before treatment, wash face and neck and remove all makeup
and/or lotions.***