PROJECT GLAMMERS™
ARTISTIC BEAUTY EXPERTS

Irene Gladstein M.D.
Ophthalmic Plastic and Reconstructive Surgery, Cosmetic Surgery

2076 East 13th Street
Brooklyn, NY 11229

44 Gramercy Park North, Suite 1B
New York, NY 10010

T:877.208.2882
F:718.382.8803
irenegladsteinmd.com

Patient information

Please print & complete

Date _____ Name :First _____ Last _____

DOB _____ Age _____ Occupation _____

Address _____City_____ State _____

Zip _____

Phone (H) _____ (C) _____ (please indicate preferred)

Email _____ (May we add you to our mailing list?
__Yes __No

You will receive Monthly Specials, Discounts and Educational Content

Signature _____Date_____

Primary Care Physician _____Phone_____

Ladies- Are you currently pregnant, trying to conceive or breastfeeding? __Yes __No

When was your LMP? ____/____/____ MM/ DD / YY

Are you currently undergoing in-vitro fertilization (IVF)? __Yes __No

Referred by _____IG Magazine Ad Internet Search Friend Groupon

Emergency Contact _____ Phone_____

Relationship_____

Current Height and Weight:

Height _____Weight _____ (is your weight stable ?) __Yes __No

Medical History

_____

_____

Surgical History (please include dates)

_____

_____

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Yes/NO chart form : Circle One

1. Any changes to your health in the last year? If yes, please explain	Yes / No
2. Do you have a history of diabetes or high blood pressure?	Yes / No
3. Have you ever had a history of a heart attack, chest pain , heart murmur and/or damaged heart valves?	Yes / No
4. Do you have a pacemaker or defibrillator?	Yes / No
5. Do you have ANY metal implants anywhere in your body?	Yes / No
6. Any history of asthma or difficulty breathing?	Yes / No
7. Do you have a history of heartburn , hiatal hernia, or ulcers?	Yes / No
8. Any history of liver disease including hepatitis?	Yes / No
9. Do you have a history of kidney disease?	Yes / No
10. Have you ever had a stroke, seizure, or fainting spells?	Yes / No

11. Do you have an arm or leg that becomes numb or weak frequently?	Yes / No
12. Do you have any thyroid problems? If yes, is it Hashimoto's?	Yes / No
13. Do you have any Auto-immune Disorders or are you being worked up for including but not limited to Lupus, Rheumatoid Arthritis, Collagen Vascular disease, etc. If yes, name of condition?	Yes / No
14. Any history of cancer? If yes, please explain:	Yes / No
15. Do you have any excessive bleeding or bruising tendencies?	Yes / No

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16. Have you ever had any facial trauma? If yes, were any of them broken bones? If yes, please describe:	Yes / No Yes / No
17. Are you currently on a blood thinner including aspirin? If yes, when was the last time you took it?	Yes / No
18. Any history of anemia or blood clots?	Yes / No
19. Any history of cold sores or herpetic lesions? (fever blisters) how often do you normally get cold sores? If yes, are you currently on standing medication to prevent cold sores?	Yes / No
20. Do you have a history of keloid scarring or poor wound healing? If yes, please describe:	Yes / No

21. Any history of anxiety/depression?	Yes / No
22. Are you under the care of a psychiatrist?	Yes / No
23. Do you have a history of Bell's (facial nerve) palsy?	Yes / No
24. Do you have a history of Myasthenia Gravis or any other neuromuscular disorder? If yes, please explain:	Yes / No
25. Do you have any chipped/loose teeth, dentures, bridges, caps, or braces?	Yes / No

Surgical History including Plastic Surgery (include dates):

Please include Appendectomy, tonsillectomy, cataract, C-section, hernia, Gall Bladder, Hysterectomy, etc.)

Facial Surgery __Yes __No

If yes, please provide list of procedures and dates

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_____

Do you have history of skin cancer __Yes __No If Yes, what type and how was it treated_____

Current Medications (please include any NSAIDS, antiplatelet medication, blood thinners ,antibiotics, steroids or any other prescription medications)

_____

_____

_____

Do you have history of steroid use or in the past 6 months? __Yes __No

Have you ever used Accutane? __Yes __No If yes, when did you last use it? _____

What topical medications or creams are you currently using? Retin-A Others (Please list)

_____

_____

_____

What herbal supplements/vitamins do you use regularly? (St. John's Wort, Vitamin E, fish oil etc.)?

_____

_____

Allergies (including drug, food)

_____

_____

Have you ever had a reaction to lidocaine? __Yes __No

Social history:

Do you smoke? YES ____ NO____ If yes how much? _____

Do you drink alcohol? YES ____ NO____ If yes, how much? _____

When was your last drink? _____

Do you use self-tanners (creams, spray-on tanners) or visit a tanning booth? YES ____ NO____ If yes how often? _____

Last time you were at a tanning booth/applied self-tanner _____

When the last time you saw the dentist? (cleaning, work etc.)

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What are your reasons for visiting the @theenhancers

- Wrinkles reduction/prevention
- Facial contouring
- Jaw slimming
- Lip contouring
- Eyelid lifts
- Facial fat reduction
- Plasma (RPR/PRFM) rejuvenation
- Skin Tone/Texture/Elasticity
- Hair Restoration
- Excess sweating
- Acne/ acne scar concerns
- Broken Capillaries/Facial redness/Rosacea
- Hyperpigmentation (Brown spots)
- Skin tightening
- Muscle stimulation
- Body Fat Reduction
- Buttock enhancement
- Cellulite Reduction
- Laser hair reduction
- Medical Aesthetics
- Medical grade skin care

Which of the following best describes your skin type? (Please circle one type number)

I Always burns, never tans

II Always bums, sometimes tans

III Sometimes burns, always tans

IV Rarely bums, always tans

V Brown, moderately pigmented skin

VI Black skin

<u>Please describe your prior facial injectable history. Please be as detailed as possible</u>

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Date	Name of injectable	Amount used	Location	Was it dissolved? (if yes, include details below)	Are you happy with results
					yes /no
					yes /no
					yes /no
					yes /no
					yes /no
					yes /no
					yes /no

Have you ever had laser or radiofrequency treatments ? If yes, which one? Date?

_____

Any history of filler dissolved? If yes, list the date and name of product.'

_____

Additional Information: Please let us know anything else you would like to discuss with us during your visit today.

_____

Our Commitment to You

Our highly trained staff are available to help you with all your skin care concerns. To ensure your treatments are best suited to you, we ask that the information you provide us be as accurate and complete as possible.

I certify that the preceding medical, surgical, personal and skin history statements are true and correct. I am aware that it is my responsibility to inform the technician, esthetician, therapist, doctor or nurse of my current medical or health conditions and to update this history. A current medical history is essential for the caregiver to execute appropriate treatment procedures.

Signature_____

Date:_____