EYE CENTER
OF NORTHERN COLORADO, P.C
CHET E. REISTAD, MD
www.chetreistadmd.com

**NAME**: ___________________________________________ **ADDRESS**: ____________________________________________________

**PHONE**: ___________________________________ **EMAIL**: _______________________________________ **DOB**:____/_____/_______

□ MALE □ FEMALE **OCCUPATION**: _______________________________________ **EMPLOYER**: ___________________________

**PRIMARY CARE PHYSICIAN NAME AND ADDRESS**: ____________________________________________________________________

**HOW DID YOU HEAR ABOUT US? PLEASE CHECK ONE:**

□ ONLINE SEARCH □ FACEBOOK □ INSTAGRAM □ FRIEND/WORD-OF-MOUTH □ EYE CENTER OF NORTHERN COLORADO WEBSITE
□CHET REISTAD MD WEBSITE □ DOCTOR REFERRAL, NAME OF PHYSICIAN:________________________ OTHER: ________________

**PLEASE INDICATE THE FOLLOWING CONCERNS: (PLEASE CHECK ALL THAT APPLY)**

| | | | |
|---|---|---|---|
| □ CROWS FEET | □ FOREHEAD LINES/FROWN LINES | □ LIP LINES | □ SKIN TEXTURE |
| □ NOSE-TO-MOUTH LINES | □ LIP VOLUME LOSS | □ BROWN SPOTS | □ THIN, SHORT EYELASHES |
| □ SKIN TEXTURE (FACE) | □ UNDER EYE CIRCLES/CREPINESS | □ EYEBROW DESENT | □ CHEEK VOLUME LOSS |
| □ FACIAL VOLUME LOSS | □ DROOPY UPPER EYELIDS | □ FAT PADS, LOWER EYELIDS | |

**PLEASE INDICATE THE FOLLOWING SERVICES YOU ARE INTERESTED IN: (PLEASE CHECK ALL THAT APPLY)**

| | | |
|---|---|---|
| □ BOTOX | □ FILLER INJECTIONS | □ EYELID SURGERY |
| □ KYBELLA | □ PELLEVE SKIN TIGHTENING | □ LASER SKIN RESURFACING |
| □ EYEBROW LIFT | □ LATISSE | □ ELTA MD SKIN/SUN CARE PRODUCTS |

**LIST ALL COSMETIC PROCEDURES AND SURGERIES THAT YOU HAVE HAD: (BOTOX, LASERS, INJECTABLES, PLASTIC SURGERY)**

| PROCEDURE | YEAR | DOCTOR/CLINICIAN |
|---|---|---|
| ___________________________________ | ________________ | _____________________________ |
| ___________________________________ | ________________ | _____________________________ |
| ___________________________________ | ________________ | _____________________________ |
| ___________________________________ | ________________ | _____________________________ |
| ___________________________________ | ________________ | _____________________________ |

**WERE THERE COMPLICATIONS?** □ YES □ NO *(IF YES, PLEASE EXPLAIN)* ____________________

**DID YOU HAVE A NORMAL RECOVERY?** □ YES □ NO *(IF NO, PLEASE EXPLAIN)* ____________________

**WERE YOU SATISFIED WITH THE RESULTS?** □ YES □ NO *(IF NO, PLEASE EXPLAIN)* ____________________

**HAVE YOU EVER BEEN DIAGNOSED WITH ANY OF THE MEDICAL CONDITIONS LISTED BELOW?: (PLEASE CHECK ALL THAT APPLY)**

□ COLD SORES □ BLEEDING DISORDERS □ IMPLANTED METAL

□ PACEMAKER □ STROKE □ HEART ATTACK

□ HEART STENT □ DEFIBRILLATOR □ BLOOD CLOTS

*FOR FEMALE PATIENTS:* **ARE YOU PREGNANT?** □ YES □ NO **BREASTFEEDING?** □ YES □ NO

**ARE YOU ON ANY BLOOD THINNING MEDICATION?** (Aspirin, Aleve, Motrin, Ibuprofen, Coumadin, Plavix, Xarelto, etc.), please list:

____________________________________________________________

**WHAT PRESCRIPTION MEDICATIONS, OVER-THE-COUNTER SUPPLEMENTS AND VITAMINS DO YOU CURRENTLY TAKE?**

____________________________________________________________

**MEDICATION ALLERGIES: (PLEASE LIST)**

____________________________________________________________

**ARE YOU CURRENTLY USING ANY FORM OF: (PLEASE CHECK ALL THAT APPLY)**

□ TETRINOIN □ RETIN A □ RETINOIC ACID □ TAZORAC □ RENOVA

**DO YOU USE SUNSCREEN?** □ YES □ NO

**DO YOU TAN ON A REGULAR BASIS?** □ YES □ NO

____________________________________________________________

**PATIENT NAME (PLEASE PRINT)** **DATE**

____________________________________________________________

**PATIENT SIGNATURE** **DATE**

____________________________________________________________

**PARENT/GUARDIAN SIGNATURE** *(IF CLIENT UNDER 18 YEARS OF AGE)* **RELATIONSHIP TO PATIENT**