MICHELE MACLEAN, M.D.

Cosmetic Medicine Health History

Name _____ **DOB**_____

Address _____

Cell _____ **Home** _____ **MSI**_____ **Exp Date**_____

Email _____ **Emerg Contact Name/Phone** _____

Family Physician _____

Do you have:

□ Cold sores/herpes _____if so, do you have access to Antiviral Medication _____
□ Special event in the next 2 weeks _____
□ Active infection _____ Antibiotics _____
□ Fainting history _____
□ Needle phobia (tell us as we can help you) _____
□ Recent or planned dental work in a 2-4 week time span _____
□ Accutane in the past 6 months _____
□ Sinus/Rhinitis infection _____
□ Skin Disease /Keloid _____
□ Bleeding disorders _____
□ HIV or Hepatitis _____
□ Allergy to Yellow Jacket Bees _____
□ Eye issues including lid drop _____
□ Body Dysmorphic Disorder or OCD _____
□ Diabetes _____
□ Steroid Therapy _____
□ Autoimmune disorder (Lupus, RA, Thyroid) _____
□ Neurological - ALS, MS, Parkinson's Dz, Myasthenia Gravis, Seizures, Numbness, Muscle Weakness_____
□ Hypertension (High Blood Pressure not under control) _____

□ Hormonal imbalance/Therapy _____

□ Kidney Disease _____

□ Cancer/Chemo/Radiation _____

□ Orthopedic implants _____

□ Pacemaker/Defibrillator _____

□ Anything else you think relevant to your care _____

□ Previous surgeries Face/Neck/ Dental_____

□ List Prescription Meds _____

□ List OTC/Herbal Meds _____

□ Allergies _____Anaphylaxis (severe allergy)_____

□ Pregnant _____ Trying in the next 6 mos _____ Not sure _____

□ Breastfeeding _____

□ Prior Botulinum_____ Last tx ____ Satisfied? If not, why _____

□ Prior Filler _____ Where/When _____

Satisfied? _____

Please be accurate so we can keep you safe. Advise us if changes occur in your health. I acknowledge I read, understood and answered the medical history truthfully.

Patient Signature _____

MD Signature _____

RN Signature _____

I am interested in:
Botulinum Neuromodulator_____

Fillers _____

Hyperhydrosis (Excessive sweating) _____

Skin tags _____

Sun Spots _____

Age Spots _____

Skin Care Advice / Products _____

Michele MacLean MD | CCFP | AAFP

902-430-0990

Cryo / Skin Surgery Consent Form

The elective surgical procedure or treatment that I requested to be performed is:

- **Skin Biopsy**
- **Removal of lesion/tumor**
- **Cryosurgery**
- **Other _____**

I _____ hereby consent to the surgical procedure or treatment that has been explained to me. I understand the following are possible risks involved,

- **Pain**
- **Bleeding, blood vessel damage**
- **Infection**
- **Scar formation (which can sometimes look worse than the original lesion)**
- **Persistent redness**
- **Increase or decrease of my skin pigmentation**
- **Recurrence of the lesion**
- **Local nerve damage or numbness, muscle paralysis**
- **Severe allergic reaction to the local anesthesia, dressings or medication**

I understand there may be other methods to do this procedure, but agree to the procedure about to be done, understanding all risks. I have been given an opportunity to ask all my questions.

I agree that photographs may be taken. I understand that specimens may be sent for microscopic evaluation. If I have questions after the procedure, I can call 902-430-0990.

SIGNATURE _____ WITNESS _____
MSI _____
DOB _____
ADDRESS _____
PHONE _____ DATE _____
PERSON & TEL NUMBER TO CALL IF NEEDED _____

To be filled out by Medical Professional:

Require antibiotics before dental work _____ Heart valve problems or murmurs _____ Artificial Joints/metal _____ Pacemaker or Defibrillator _____ Any Asprin / Advil etc. past week ____ Latex Allergy _____ Any adverse reactions to local anesthetics or epinephrine _____ Any chance pregnant _____ Driver needed _____

Consent to Use Electronic Communications

Michele MacLean, M.D.
drmml2001@gmail.com
902-430-0990
www.michelemacleanmd.com

Dr. MacLean has offered to communicate using the following means of electronic communication the services [check all that apply]:

Email _____

Text _____

Video conferencing (Webex, Teams) _____

Social media _____

Website _____

Client Acknowledge and Agreement:

I acknowledge that I have read and fully understand the risks, limitations, conditions of use, and instructions for use of the selected electronic communication.

I acknowledge and understand that despite recommendations that encryption software be used as a security mechanism for electronic communications, it is possible that communications with the Physician or the Physician's staff using the Services may not be encrypted. Despite this, I agree to communicate with the Physician or the Physician's staff using these Services with a full understanding of the risk.

I acknowledge that either I or Dr. MacLean may, at any time, withdraw the option of communicating electronically through the Services upon providing written notice. Any questions I had have been answered.

Name: _____

Address: _____

Phone: _____

Email _____

Client signature: _____ **Date:** _____

Witness signature: _____ **Date:** _____