PATIENT INTAKE FORM

DATE: ____/_____/__________

NAME (last, first) ____MIDDLE____________

Address____City___________Zip_________

Date of Birth: ____/_____/________ Age_______ S.S.# _______/_____ /____________

Occupation ____

Employer (Name and Address) ____

E-mail address_________________________________@______________.

In case of Emergency Contact____

Phone #___________________________________Relationship_________________________

Primary Physician (Address & Phone if possible) _______________________________________

	CONTACT INFORMATION	**Best number to contact you? √ one**
Home phone number	( )	
Work phone number	( )	
Cell phone number	( )	

HOW WERE YOU REFERRED TO OUR OFFICE?

FRIEND____________________ May we thank them? Yes____ No _____ Walk-in _________

PHYSICIAN__________________________ Phone Number ( ) _____________________

INTERNET: GOOGLE______ YAHOO_____ OTHER_____________ YELLOW PAGES______

CONFIDENTIALITY

Records and documents are released to patients with prior written consent. In every respect, your interactions with this office remain totally private and discreet.

MEDICAL HISTORY INFORMATION
Please fill out this 2 SIDED form completely

Name________________________________ Birthdate__________________ Date___________

REVIEW OF SYSTEMS

YES NO

___ ___ Are you allergic to any medication, list
___ ___ Eye problems, infections or injuries
___ ___ Nasal problems, difficulty breathing, nose injuries
___ ___ Heart disease or heart problems
___ ___ Lung problems, pneumonia, TB, asthma, congestion
___ ___ Thyroid, endocrine, or hormonal problems
___ ___ Kidney, bladder or liver problem
___ ___ Stomach, intestinal, bowel, hemorrhoid, ulcers, bleeding or digestion problems
___ ___ Throat problems, difficulty swallowing
___ ___ Muscle or bone problems
___ ___ Reproductive organs, problems?
___ ___ Epilepsy, convulsions, seizures?___ ___ Nervous disorder, or depression
___ ___ Blood or blood vessels problems?

MEDICAL HISTORY

___ ___ Migraine headaches
___ ___ HIV or AIDS
___ ____ HEPATITIS (A, B or C) is yes: _________
___ ___ Herpes, cold sores or shingles
___ ___ Breast problems
___ ___ Any abnormal test or x-ray ever
___ ___ Diabetes
___ ___ Cancer of any kind
___ ___ Problems in sleeping

ABILITY TO HEAL/SKIN CONDITION

___ ___ Bleeding problems with cuts, tooth extractions, pregnancy or surgery
___ ___ Difficulty or nausea with local or general anesthesia
___ ___ Have you had any recent facial surgery, Botox or other injectables?
___ ___ Do you have any permanent makeup?
___ ___ History of skin sensitivity? Explain
___ ___ Have you ever taken Accutane?
___ ___ Have you ever used Retin A (tretinoin) or Avage(Tazaratene)
___ ___ Are you using any topical medications on your skin?
___ ___ Skin cancer, skin biopsies,family history of skin cancer
___ ___ Any skin discoloration, hyperpigmentation, dark patches
___ ___ Fine lines, deep lines, wrinkles
___ ___ Acne breakouts, blackheads, pustules, acne scars
___ ___ Rough skin texture
___ ___ Does your skin tan easily (rarely burns)
___ ___ Does your skin burn easily (rarely tans)
___ ___ Do you use any topical medications on your skin
___ ___ Do you smoke? How much? ________/packs a day.
___ ___ Hair removal treatments, wax, electrolysis, laser
___ ___ Keloids (thick, fibrous scar) or scars
___ ___ Easily bruise, slow healing

Skin Type: Oily ___Dry ___Combination ___Normal ___Thick ___Thin ___Normal ___

2 SIDED MEDICAL HISTORY FORM

Name____Date____ _______________

Are you currently being seen by a physician for any condition, please explain:

Are you pregnant, breastfeeding or attempting pregnancy? _______________________________

Please list all medications (any drug or medicine) you are currently taking:

Admissions to hospital, give reason, date, complications or difficulties:

Surgeries, give type, date, complications or difficulties:

Previous resurfacing procedures (please give dates)
CO2_______Erbium_______IPL_______Peels: TCA _____Glycolic _____Other____________

Family history of any medical problems or illnesses,

What was the date of your last physical examination?

Do you exercise? No______ Light________ x per week Vigorous_____ x per week

Current Weight_______ Ideal wt._______1 year ago_______ 5 years ago______ Height_______

Consumption of alcohol: None _____Daily _______Weekly _______Rare/Social______
Consumption of aspirin or aspirin products

List any vitamins or supplements you are taking

What would you like to discuss in your consultation today? _______________________________