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We are dedicated to providing you with the best care possible.
Please help us do so by providing us with the following important health information. Thank you!

PATIENT NAME:_____ TODAY'S DATE:_____
DATE OF BIRTH:_____ SEX:_____ MARITAL STATUS:_____
TYPE OF WORK:_____ # OF CHILDREN:_____

Height_____ Weight_____ Age _____
DRUG ALLERGIES? ☐ NO KNOWN DRUG ALLERGIES ☐ Yes, Please specify:_____
FOOD ALLERGIES? ☐ NO KNOWN FOOD ALLERGIES ☐ Yes, Please specify:_____
LATEX ALLERGY? ☐YES ☐ NO ADHESIVE TAPE ALLERGY? ☐ YES ☐ NO

PRIMARY CARE PHYSICIAN_____ Date of last physical exam _____
PRIOR SURGERY Procedure_____ Year_____ Surgeon/Location_____
Procedure_____ Year_____ Surgeon/Location _____
Procedure_____ Year_____ Surgeon/Location_____
Procedure_____ Year_____ Surgeon/Location _____

FOR WOMEN

☐ YES ☐ NO Personal or family history of breast cancer Bra size _____
☐ YES ☐ NO Breast mass ☐ YES ☐ NO Nipple discharge ☐ YES ☐ NO Breast pain
☐ YES ☐ NO Are you or could you be pregnant? Have you ever had a mammogram? ☐ YES ☐ NO Date of most recent_____
PREGNANCIES Year _____ ☐ Vaginal Delivery ☐ C-section Year _____ ☐ Vaginal Delivery ☐ C-section
Year _____ ☐ Vaginal Delivery ☐ C-section Year _____ ☐ Vaginal Delivery ☐ C-section

MEDICATIONS:

PRESCRIPTION: Medication:_____ Dose_____ Medication:_____ Dose_____
Medication:_____ Dose_____ Medication:_____ Dose_____
Medication:_____ Dose_____ Medication:_____ Dose _____
OVER THE COUNTER MEDICATIONS:
Medication:_____ Dose_____ Medication:_____ Dose_____
Medication:_____ Dose_____ Medication:_____ Dose _____
HERBAL/DIETARY SUPPLEMENTS:
Medication:_____ Dose_____ Medication:_____ Dose_____
Medication:_____ Dose_____ Medication:_____ Dose _____

MEDICAL HISTORY - DO YOU HAVE OR HAVE YOU EVER HAD:

☐ YES ☐ NO Do you exercise regularly? What type _____
☐ YES ☐ NO Heart disease (including: heart murmur, pacemaker, catheterization, stents, surgery, mitral valve prolapsed)
Specify:_____
☐ YES ☐ NO Chest pain
☐ YES ☐ NO Previous EKG/stress test/echocardiogram Date(s) _____
☐ YES ☐ NO High blood pressure
☐ YES ☐ NO Asthma
☐ YES ☐ NO Hospitalizations, IF YES, how many _____
☐ YES ☐ NO Lung disease Specify _____
☐ YES ☐ NO Chronic cough
☐ YES ☐ NO Shortness of breath
☐ YES ☐ NO Sleep apnea
☐ YES ☐ NO CPAP machine If YES, do you use it nightly? ☐ YES ☐ NO
☐ YES ☐ NO Liver disease/hepatitis/jaundice Specify _____
☐ YES ☐ NO Diabetes Type & Date of Diagnosis_____
Do you take insulin? ☐ YES ☐ NO Last Hemoglobin A1C level _____
☐ YES ☐ NO Are you on a special diet? Specify _____

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☐ YES ☐ NO Recent weight loss? If yes, was it purposeful? ☐ YES ☐ NO How much weight loss? _____
☐ YES ☐ NO Anemia
☐ YES ☐ NO Epilepsy/Seizures/Stroke/Neurological problems Specify _____
☐ YES ☐ NO Autoimmune disorders/connective tissue disorders/lupus/sarcoid Specify _____
☐ YES ☐ NO Psychological conditions (depression/anxiety, bipolar, schizophrenia, etc.) Specify _____
☐ YES ☐ NO Thyroid or goiter problems Specify _____
☐ YES ☐ NO Bowel/colon disease or problems Specify _____
☐ YES ☐ NO Frequent heartburn/indigestion, esophageal reflux, hiatal hernia
☐ YES ☐ NO Glaucoma
☐ YES ☐ NO Dry eyes
☐ YES ☐ NO Use eye drops
☐ YES ☐ NO Back and/or neck problems Specify _____
☐ YES ☐ NO Hepatitis If yes, type (A, B, C)?_____Date diagnosed _____
☐ YES ☐ NO HIV If yes, date diagnosed _____
☐ YES ☐ NO MRSA If yes, date diagnosed _____
☐ YES ☐ NO Past/present carrier of other contagious/infectious disease Specify _____
☐ YES ☐ NO Exposure to communicable diseases in the past 3 weeks Specify _____
☐ YES ☐ NO Personal or family history of deep venous thrombosis (DVT, blood clots in legs or lungs) _____
☐ YES ☐ NO Personal history of bleeding or clotting abnormality (e.g. Factor V Leiden, lupus anticoagulant) _____
☐ YES ☐ NO Family history of bleeding or clotting abnormality (e.g. Factor V Leiden, lupus anticoagulant) _____
☐ YES ☐ NO History of blood transfusions Specify _____
☐ YES ☐ NO Do you or have you ever smoked? Amount per day_____How many years_____Year quit ____
☐ YES ☐ NO Use(d) smokeless tobacco How many years_____Year quit _____
☐ YES ☐ NO Use(d) recreational drugs types(s)_____How much_____How many years __
☐ YES ☐ NO Use(d) alcohol type(s)_____How much _____
☐ YES ☐ NO Been treated for substance abuse type(s)_____When ____
☐ YES ☐ NO Steroid use in the past 12 months Specify _____
☐ YES ☐ NO Keloids or unusually large scars
Malignant Hypothermia
Any significant family history of disease If yes, please explain:_____

ANESTHESIA HISTORY

☐ YES ☐ NO Have you ever had a reaction to a regional or local anesthesia injection? If yes, specify _____
☐ YES ☐ NO Have you ever had a general anesthesia? _____
☐ YES ☐ NO Have you ever had problems with anesthesia? Specify _____
☐ YES ☐ NO Have members of your family had problems with anesthesia? Specify _____

DO YOU HAVE OR WEAR ANY OF THE FOLLOWING?

☐ YES ☐ NO Dentures
☐ YES ☐ NO Eye Glasses
☐ YES ☐ NO Contact Lens

I HAVE ANSWERED ALL OF THESE QUESTIONS FULLY AND TO THE BEST OF MY KNOWLEDGE. I UNDERSTAND THAT I SHOULD INFORM MY PHYSICIAN IF I EXPERIENCE ANY NEW HEALTH ISSUES OR IF THE STATUS OF MY EXISTING HEALTH ISSUES CHANGES.

_____ _____ _____ _____
Patient Signature Date Parent/Guardian/Next of Kin (if patient unable to sign) Relationship

FOR OFFICE USE ONLY

Patient is NOT eligible for the treatments and products checked below. All others are authorized. Skin type:_____

Laser/Treatments:	**Products:**	**Injectable:**
☐Permanent laser hair reduction	☐Facial w/chemical peel	☐Botox
☐Laser vein therapy	☐Latisse ☐Hydroquinone	☐Dermal Fillers
☐Intense pulsed light treatment (IPL)	☐Salicylic Acid	☐Sub dermal – local injectable
☐SmartSkin Fractional CO2	☐Glycolic Acid	☐Dental block
☐ Ultherapy	☐Blue Peel	☐Topical Anesthestic
☐Microdermabrasion	☐Retin-A	☐Scar Therapy w/Kenalog
☐Dermaplaning	☐Melange Peel	☐Schlerotherapy

(PHYSICIAN ONLY) *FORM REVIEWED WITH PATIENT* _____, M.D. Date _____

Updated_____Patient Signature_____Physician Signature _____