Patient Information

Patient information as of today's date: ___________________________
(Please print legibly and fill in all fields. If information is not available, please put N/A.)

Personal Information

Patient Name ______________________________ SSN:______________________ DOB _______________

Address ____ Apt# _______________

City ______________________________________ State ______________________ Zip _______________

Cell Phone (______)______________________ Home Phone (______)__________________________

Work Phone (______)_____________________ Email Address ____________________________

Occupation ________________________________ Employer _______________________________

Preferred Language ________________________ Sex: € Male € Female

Emergency Contact Name/Phone Number ____________________________ # (_____)_______________

Reason for your visit today?

____

Date of last physical ________________________ Name of Primary Physician ________________________

Is your general health good? € Yes € No

Allergies? € Yes € No Known Drug Allergies
If yes, please list: ____

List all medications you are taking (prescription and OTC):

____

____

Do you take Aspirin, Advil, Motrin, Ibuprofen or anti-inflammatory medication more than once per week?
€ Yes € No If yes, please explain: ____
Do you smoke? € Yes € No If yes, how many per day/for how many years: ______________________
Do you drink alcohol? € Yes € No If yes, how much/how often: ______________________________
Do you regularly use a tanning bed or sun exposure? € Yes € No If yes, how much/how often: ______

____

Do you regularly take vitamins? € Yes € No If yes, what kind and how often: ______________________
Are you currently pregnant? € Yes € No Are you currently breastfeeding? € Yes € No
Are you currently trying to become pregnant? € Yes € No

Present/Past Medical History

Have you ever had any of the following (please check all that apply):

€ Asthma
€ Autoimmune disorder
€ Chronic diarrhea
€ Diabetes
€ Excessive scarring
€ Heart valve disease
€ High/ low blood pressure
€ Irregular heart beat
€ Kidney disease
€ Multiple Sclerosis
€ Migraines
€ Seizures
€ Unusual mole
€ Thyroid disorder

€ Arthritis
€ Blood disorder
€ Clotting disorder
€ Depression
€ Excessive bleeding
€ Heart valve replacement
€ Hepatitis
€ Intestinal problems
€ Liver disease
€ Muscular Dystrophy
€ Rheumatic fever
€ Stomach problems
€ Tattoo/ permanent makeup

€ Anemia
€ Chest Pain
€ Colon problems
€ Easily Bruise
€ Heart Attack
€ Heart Failure
€ HIV
€ Keloids
€ Lung disease
€ MVP
€ Shortness of breath
€ Varicose veins
€ Stroke

€ Cancer: Please list type: ____________________________

Please list all surgeries or hospitalizations with dates:

____Date____________________
____Date____________________
____Date____________________
____Date____________________

Please list any cosmetic procedures you have had (surgical and non-surgical) with dates:

____Date____________________
____Date____________________
____Date____________________
____Date____________________

Please describe your current skin care process

____
____
____
____

Please list any substances that irritate your skin

Please list any concerns that you have?

Please list any treatments or products that interest you.

To the best of my knowledge, the information provided above is true and accurate. I agree to tell the staff of any changes to my health history or medications as they arise. I understand that information is necessary for your practice and will remain confidential. All efforts are routinely made to ensure privacy is upheld.

Printed Patient Name **Date**

Signature of Patient

Practice Representative Name

Signature of Practice Representative