PATIENT INFORMATION FORM

Welcome to our office and thank you for completing this form.

Patient Information

Last Name: ____________________________ First Name: ____________________________ Middle Initial: ____

Date of Birth: _____________ Age: ________ Sex: ________ SS#: _____________________________________

Street Address: ____

City: _______________________ State: _____ Zip: __________ Home Phone (______) _________________

Email: ____ Cell Phone (_______) _________________

❑ Mail Only ❑ Email Only

Responsible Party: ________________________ Patient Relationship: ❑ Self ❑ Spouse ❑ Child ❑Other

❑ Single ❑ Married ❑ Full-Time Student ❑ Part-Time Student

Address: (If different) ____

City: _______________________ State: _____ Zip: __________ Phone (______) _______________________

Employer's Name: ______________________________________ Occupation: ____________________________

Employer's Address: ____

City: _______________________ State: _____ Zip: __________ Phone (______) _______________________

Referred By: ____

Spouse Information

Last Name: ____________________________ First Name: ____________________________ Middle Initial: ____

Date of Birth: _____________ Age: ________ Sex: ________ SS#: _____________________________________

Employer's Name: ______________________________________ Occupation: ____________________________

Employer's Address: ____

City: _______________________ State: _____ Zip: __________ Phone (______) _______________________

Other Information

Name of nearest relative (not living with you) ___________________________ Relationship: __________________

City: _______________________ State: _____ Zip: __________ Phone (______) _______________________

Pharmacy Information:

Name of your Pharmacy: _______________________________

Address (major cross streets) of Pharmacy: __________________________________

Phone Number of Pharmacy (very helpful): ___________________________

PATIENT HEALTH HISTORY FORM

Information contained here will be treated in a confidential manner and not released without your authorization. Please take the time to answer all appropriate questions to the best of your knowledge, as this information is important to your doctor in his decisions regarding your care.

Date: ______________ Name: ________________________________ Age: _______ Date of Birth: ____________________

Height: ______________ Weight: ____________ Ideal Weight: ____________ Sex: _____ Marital Status: ______________

Referred By: ______________________________ Personal Physicians: ______________________________

Employment: ____

MEDICATIONS	Yes	No		Yes	No		Yes	No
Pain Medication	❑	❑	Cortisone/Steroids	❑	❑	Antibiotics	❑	❑
Blood Thinners	❑	❑	Weight Loss Pills	❑	❑	Birth Control Pills	❑	❑

List all names of meds (with amounts and how often) taken: ____

____

____

MEDICATION ALLERGIES / SENSITIVITIES	Yes	No		Yes	No		Yes	No
Penicillin	❑	❑	Other Antibiotics	❑	❑	Other	❑	❑
Sulfa Drugs	❑	❑	Aspirin	❑	❑			

List reactions which have occurred for each above "Yes" response: ____

____

SURGICAL HISTORY

List all previous operations, dates and any complications:

Date	Age	Operation	Physician/Hospital	Complications

Are you pregnant? ❑ Yes ❑ No How many pregnancies have you had? ____ Did you breast feed? ❑ Yes ❑ No

Date/Result Last Mammogram: ____

MEDICAL HISTORY	Yes	No		Yes	No		Yes	No
Bleeding Problems/Anemia	❑	❑	High Blood Pressure	❑	❑	Eye Problems	❑	❑
Anesthesia Problems	❑	❑	Herpes/Cold Sores	❑	❑	Heart Attack/Disease	❑	❑
Scarring Problems	❑	❑	Breast Disease	❑	❑	Other	❑	❑
Diabetes	❑	❑						

Explain and give dates for each of the above "Yes" responses: ____

____

____

Do you use alcohol? ❑ No ❑ Yes ❑ Light ❑ Heavy

Do you Smoke: ❑ Yes ❑ No Avg. # packs a day: __________ # of years ________ Date Quit: ____________

FAMILY HISTORY	Yes	No		Yes	No		Yes	No
Bleeding Problems	❑	❑	High Fever from Surgery	❑	❑	Other Cancer	❑	❑
Anesthesia Problems	❑	❑	Breast Cancer	❑	❑			

List family members and explanation if necessary for each above "Yes" response: ______________________________

____

Patient Signature: ______________________________ Physician Signature: ______________________________

PATIENT SKIN CARE HISTORY

Do you currently see a Nurse Injector or Aesthetician for your skincare? Yes_____ No _____
If yes, please explain ____

Please list all of the nonsurgical skincare services you've received: ________________________
____
Are you happy with your skincare provider(s)? Yes _____ No _____
If no, why not ____

What are your skincare goals? ____
____
List any topical medications (prescription or over the counter) you use or have used:
Acne_______ Retin-A/ Renova_____ Glycolic Acid _____ Differin _______ Other__________

Is There anything that bothers you about your skin? ____________________________________
____
____

When looking at my face in the mirror, I believe I look younger, the same as, or older than my true age.

Younger Than		**True Age**		**Older Than**
1	**2**	**3**	**4**	**5**

Does your skin appear fragile or burn easily? Yes _____ No _____
Have you ever had Botox or Dysport treatment? Yes _____ No _____
Have you ever had a filler treatment? Yes _____ No _____
Have you ever had a chemical peel? Yes _____ No _____

Are you happy with your current skincare products? Yes _____ No _____
If not, please explain: ____

Do you use daily sun protection? Yes _____ No _____ SPF _____

Do you use tanning beds? Yes ______ No ______ Frequency ___________________________

Describe your daily skincare routine:
A.M.____
____
P.M.____
____