# 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: _____

Street Address: _____

City: _____ State: _____ Zip: _____ Home Phone (_____) _____

Email: _____ Cell Phone (_____) _____

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

Employer's Name: _____ Occupation: _____

Employer's Address: _____

City: _____ State: _____ Zip: _____ Phone (_____) _____

Referred By: _____

*Spouse or Significant other information:*

Last Name: _____ First Name: _____ Middle Initial: ____

Date of Birth: _____ Age: _____ Sex: _____

Employer's Name: _____ Occupation: _____

*Other Information*

Nearest relative or friend (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:**_____

# 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._____
_____