

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

Pain Medication	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Cortisone/Steroids	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Antibiotics	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Blood Thinners	<input type="checkbox"/>	<input type="checkbox"/>	Weight Loss Pills	<input type="checkbox"/>	<input type="checkbox"/>	Birth Control Pills	<input type="checkbox"/>	<input type="checkbox"/>

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

MEDICATION ALLERGIES /

SENSITIVITIES

Penicillin	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Other Antibiotics	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Other	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Sulfa Drugs	<input type="checkbox"/>	<input type="checkbox"/>	Aspirin	<input type="checkbox"/>	<input type="checkbox"/>			

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

Bleeding Problems/Anemia	Yes <input type="checkbox"/>	No <input type="checkbox"/>	High Blood Pressure	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Eye Problems	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Anesthesia Problems	<input type="checkbox"/>	<input type="checkbox"/>	Herpes/Cold Sores	<input type="checkbox"/>	<input type="checkbox"/>	Heart Attack/Disease	<input type="checkbox"/>	<input type="checkbox"/>
Scarring Problems	<input type="checkbox"/>	<input type="checkbox"/>	Breast Disease	<input type="checkbox"/>	<input type="checkbox"/>	Other	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>						

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

Bleeding Problems	Yes <input type="checkbox"/>	No <input type="checkbox"/>	High Fever from Surgery	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Other Cancer	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Anesthesia Problems	<input type="checkbox"/>	<input type="checkbox"/>	Breast Cancer	<input type="checkbox"/>	<input type="checkbox"/>			

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. _____
