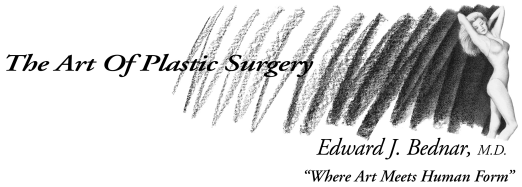

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■ Patient Information

Today's Date: _____

Title: Dr. Mr. Mrs. Ms. _____ Name (Last, First, Middle) _____

Gender: ☐ M ☐ F Age: _____ Birthdate: _____ Social Security: _____

Street Address _____

City, State & ZIP _____

Home Phone _____ Cell Phone _____ Work Phone _____

Email address _____

☐ Check if Minor (less than18) Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Pharmacy Name: _____ Phone: _____

Primary Care Physician (PCP): _____ Phone: _____

Address: _____

Permission to contact PCP regarding care and to inform of treatment course: ☐ Yes ☐ No

■ How did you hear of us?

☐ Friend: _____ ☐ Newspaper: _____

☐ Our patient: _____ ☐ Our Website: _____

☐ Magazine: _____ ☐ Television: _____

☐ Physician referral: _____ Phone: _____

Address: _____

Would you like to receive email announcements on special discounts, new products, or procedures?.....☐ Yes ☐ No

If Yes, what email address can we send it to? _____

■ Authorization

I hereby authorize medical treatment of the person named above, and agree to pay all fees and charges for treatments and services rendered. I understand that medical treatment may include a review of personal, social and medical history, discussion of the reason(s) for the visit(s), and may include photographs of the area(s) being discussed and or treated before and/or after treatment. I have read and agreed to the above.

Signature: _____ Date: _____

If the patient is a minor (under 18 years of age), the responsible parent or guardian must sign above, and fill in the information below.

Parent/Guardian Name (print): _____ Relationship to Patient: _____

Please note that we require a copy of your government-issued photo identification for your record.

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Patient Name: _____ **Date:** _____

List the reason(s) for your visit today: _____

List all medical conditions for which you are presently being treated: _____

_____

List all skin conditions you have previously been diagnosed with and/or treated for: _____

_____

■ Personal Medical History

Please mark all past and present medical conditions:

Cardiovascular:
☐ High blood pressure
☐ Heart attack(s)
☐ Pacemaker
☐ Coronary artery disease
☐ Murmur / Mitral valve prolapse
☐ Irregular heartbeat / palpitations
☐ Other: _____

Pulmonary:
☐ Asthma
☐ Chronic lung disease
☐ Chronic cough
☐ Shortness of breath
☐ Sleep Apnea
☐ Other: _____

Neuromuscular:
☐ Arthritis
☐ Muscle weakness
☐ Nerve damage
☐ Facial paralysis / Weakness
☐ Headaches
☐ Seizure disorder / Convulsions
☐ Spinal / Back disorders
☐ Other: _____

Psychological:
☐ Depression
☐ Anxiety
☐ Claustrophobia
☐ Receive(d) psychiatric treatment
☐ Drug / Alcohol dependency treatment
☐ Psychiatric hospitalization
☐ Other: _____

Ears / Nose / Throat:
☐ Dental Braces / Implants / Crowns
☐ Nasal Difficulties
☐ Difficulty breathing by nose
☐ Difficulty opening mouth
☐ Previous nasal injury
☐ History of sinus infections
☐ Hearing difficulty
☐ Hoarseness
☐ Other: _____

Eyes:
☐ Dry eye
☐ Blurred / Double vision
☐ Cornea problems
☐ Glaucoma
☐ Thyroid eye disease
☐ Wears glasses or contacts
☐ Other: _____

Endocrine:
☐ Diabetes
☐ Thyroid disease
☐ Lupus
☐ Other: _____

Hepatic:
☐ Hepatitis (Type: ___)
☐ Pancreatitis
☐ Cholecystitis
☐ Other: _____

Renal:
☐ Renal failure
☐ Dialysis
☐ Other: _____

Hematology:
☐ Anemia - Low hemoglobin
☐ Blood Clots
☐ Blood transfusion
☐ Bleeding disorder
☐ Bruise Easily
☐ Other: _____

Gastrointestinal:
☐ Anorexia/Bulimia
☐ Colitis
☐ Reflux disease
☐ Stomach ulcers
☐ Other: _____

Allergic / Immunologic / Infectious:
☐ Hay fever
☐ HIV / AIDS
☐ Sexually transmitted disease
☐ Staph / Strep / MRSA
☐ Tuberculosis (TB)
☐ Autoimmune disorder
☐ Other: _____

Dermatological:
☐ Excessive sweating
☐ Cold sores / herpes
☐ Acne
☐ Rosacea
☐ Eczema
☐ Psoriasis
☐ Radiation to face / neck
☐ Scarring / Keloid formation
☐ Slow wound healing
☐ Other: _____

Cancer:
☐ Basal cell cancer
Location: _____
☐ Squamous cell cancer
Location: _____
☐ Melanoma
Location: _____
☐ Breast cancer
☐ Ovarian cancer
☐ Lung cancer
☐ Colon cancer
☐ Prostate cancer
☐ Other: _____

Please list any other conditions not listed above: _____

Do you faint easily? ..... ☐ Yes ..... ☐ No

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Patient Name: _____ **Date:** _____

For Females Only:

Do you have any personal history of breast cancer? .....☐ Yes .....☐ No
If yes, who is your treating physician? _____ Phone: _____
Are you still in treatment? .....☐ Yes .....☐ No
Do you have any family history of breast cancer? .....☐ Yes .....☐ No
If yes, please list all relatives: _____
When was your last mammogram? _____ Was it normal?..... ☐ Yes ..... ☐ No
Are your currently pregnant? .....☐ Yes .....☐ No
If no, are you planning to? .....☐ Yes .....☐ No
Are your currently nursing? .....☐ Yes .....☐ No
List dates of all pregnancies? _____
Have you ever had a Cesarean (C-Section)? .....☐ Yes .....☐ No If yes, how many? _____
If yes, when was your most recent Caesarian? .....☐ Yes .....☐ No
For breast-related surgical patients only: What is your bra size? _____

■ Personal Surgical History

Procedure	Date

Have you ever had any surgical complications? .....☐ Yes.....☐ No
If yes, please describe: _____

■ Medications

List all medications you are currently taking, both by mouth and topically, including prescriptions (such as birth control, blood thinners, etc.), over-the-counter treatments, vitamins, herbal supplements and creams. Please let us know the reason you are taking each medication.

Medication	Dosage & Frequency	Length of Time Used	Reason Taking Medication

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Patient Name: _____ **Date:** _____

Are you currently, or have you recently, taken any medications containing Aspirin? ..... ☐ Yes ..... ☐ No
Have you been on Accutane therapy within the past 24 months? ..... ☐ Yes ..... ☐ No
Have you taken any steroid preparation(s) over the past year? ..... ☐ Yes ..... ☐ No

■ Allergies

☐ **If you have no allergies at all, check this box and skip to the next section.**

If you do have allergies, please check all items that you have had an allergic reaction to:

☐ Penicillin ☐ Sulfa ☐ Lidocaine ☐ Novocaine ☐ Eggs ☐ Latex

If you marked any of the above, please describe the reaction(s): _____

Please list all other drug and food allergies, including products such as tape , and the nature of your reaction:

_____

_____

■ Family Medical History

Please mark which of your relatives have or had the following conditions. List which blood relative are / were affected.

	Mother	Father	Blood Relative(s)
Allergies	☐	☐	_____
Arthritis	☐	☐	_____
Asthma	☐	☐	_____
Cancer (except skin cancer)	☐	☐	_____
Diabetes	☐	☐	_____
Eczema	☐	☐	_____
Heart Disease	☐	☐	_____
High Blood Pressure	☐	☐	_____
Lung Disease	☐	☐	_____
Psoriasis	☐	☐	_____
Tuberculosis	☐	☐	_____
Other skin condition	☐	☐	_____
Basal Cell Carcinoma	☐	☐	_____
Squamous Cell Carcinoma	☐	☐	_____
Melanoma	☐	☐	_____

Were you adopted? ..... ☐ No ..... ☐ Yes If Yes, do you know your biological family's medical history? ..... ☐ No ..... ☐ Yes

■ Social History

Do you smoke? ..... ☐ No ..... ☐ Yes (#/Day: _____) ..... ☐ I did, but I quit (Quitting date: _____)
Do you drink alcohol? ☐ No ☐ Yes If Yes, frequency:_____ Recreational drugs? ☐ No ☐ Yes. If Yes, frequency:_____
How often do you exercise? ..... ☐ Daily ..... ☐ 1 x per week ..... ☐ 2-3 x per week ..... ☐ 4-6 x per week
Do you use sunscreen? ..... ☐ Daily ..... ☐ Always if sunny ..... ☐ Sometimes if sunny ..... ☐ Rarely / Never
What brand facial soap do you use? _____ What brand moisturizer do you use? _____
What brand body soap do you use? _____
Are you using birth control? ..... ☐ No ..... ☐ Yes .....If Yes, method: _____

■ Review of Systems

Have you had any significant weight change in the past year? _____ lb loss _____ lb gain ☐ No
What is your height? _____ What is your current weight? _____

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Parent/Guardian Name (print): _____ Relationship to Patient: _____

COSMETIC & AESTHETIC INTEREST QUESTIONNAIRE

Patient Name: _____ **Date:** _____

Please mark all products, procedures and treatments which you are interested in.

■ Cosmetic Dermatology

- ☐ Fine Lines and Wrinkles
  - Botox Cosmetic
- ☐ Nonsurgical brow lift
- ☐ Chemical peel
- ☐ Eyelashes- Longer/Fuller/Darker
- ☐ Facial Fillers
  - Juvederm
  - Belotero
  - Restylane
  - Radiesse
- ☐ Lip augmentation
- ☐ Laser skin resurfacing
- ☐ Laser skin tightening
- ☐ Laser Facial Peel
- ☐ Laser stretch mark reduction
- ☐ Age spot reduction
- ☐ Torn earlobe repair
- ☐ Hair replacement/restoration

■ Plastic Surgery

- ☐ Face lift
- ☐ Neck lift
- ☐ Fat transfer/grafting
- ☐ Eyelid lift/surgery
- ☐ Nose contouring
- ☐ Chin augmentation
- ☐ Fat grafting to the breast
- ☐ Breast augmentation
- ☐ Breast reduction
- ☐ Breast lift
- ☐ Breast augmentation removal
- ☐ Breast augmentation revision
- ☐ Liposuction
- ☐ Male breast reduction
- ☐ Tummy tuck
- ☐ Arm lift
- ☐ Thigh lift
- ☐ Cellulaze

■ Aesthetician Treatments

- ☐ Microdermabrasion
- ☐ Facial
- ☐ Clear & Brilliant
- ☐ Masque
- ☐ Hair waxing
- ☐ Dermaplane
- ☐ Eyebrow shaping
- ☐ Eyebrow/Eyelash Tinting
- ☐ Peels