PATIENT INFORMATION

Patient information as of today's date: ___________________________

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 _____________________________ # (______)________________

How did you hear about us?

____

Health History

Are you currently under the care of a physician?

Date of last physical _________________________ Name of Primary Physician ________________________

Do you have any 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 regularly take vitamins? Yes No If yes, what kind and how often: __________________________

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 regularly use a tanning bed or sun exposure? Yes No If yes, how much/how often: _________

Are you currently pregnant? Yes No Are you currently breastfeeding? Yes No

Are you currently trying to become pregnant? Yes No

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

Asthma	Arthritis	Autoimmune disorder
Anxiety	Blood disorder	Chest Pain
Clotting disorder	Diabetes	Depression

Easily bruise	Heart Attack	Hepatitis
High/low blood pressure	Heart valve disease/condition	High cholesterol
HIV	Hypertrophic scars/Keloids	History of cold sores
Multiple sclerosis	Migraines	Muscular dystrophy
Rheumatoid arthritis	Seizures	Sjogren's disease
Thyroid disorder	Cancer: Please list type: ___________________________	

Please list all surgeries or hospitalizations with approximate dates:

____Date___________________
____Date___________________
____Date___________________
____Date___________________

Please list any aesthetic treatments you have had (surgical and non-surgical: ie. facelift, blepharoplasty, rhinoplasty, botox, fillers, laser treatments, etc) with approximate dates:

____Date___________________
____Date___________________
____Date___________________
____Date___________________

Please describe your current skin care regimen:

____
____
____
____

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**