Patient Information

General Information

Welcome to our office. To better help us evaluate you, please complete the following form. If you have any questions, we will be happy to help you. Thank you.

Name _____ Occupation _____

Birth Date _____ Age _____

Address _____

City _____ State _____ Zip code _____

Home #_____ Work # _____ Cell # _____

Email _____

How did you hear about us? Please be specific.

Friend/Family _____

Radio-What station where you listening to? _____

Physician Office _____

Print Ad- Where was the ad? _____

Internet- Which Web site? _____

TV- What station were you watching? _____

What procedures are you interested in?

_____ Weight Loss Program

_____ Hormone Replacement

_____ Skin Care

_____ Microdermabrasion

_____ Laser Hair Removal

_____ Photo Facial

_____ Radiesse, Juvederm, Artefill

_____ Vein Treatment

_____ Fraxel Laser Resurfacing

_____ Botox

_____ Breast Augmentation

_____ Breast Reduction

_____ Rhinoplasty

_____ Liposuction

_____ Tummy Tuck

Medical History

Primary Care Doctor: _____

List all medications: _____

_____

List any surgeries that you have had and when they were performed: _____

_____

_____

Do you have any drug allergies: ☐ Yes ☐ No Drug _____

Past Medical History:
(Please circle any illnesses that you have been treated for: items not circled are understood to be negative)

Abnormal Bleeding	Pneumonia	Cancer	Diabetes	Heart Disease
High Blood Pressure	Ulcer	Hepatitis	Kidney Disease	Anemia
AIDS/HIV Positive	Arthritis	Liver Disease	Asthma	Gout
Peripheral Vascular Disease	Anxiety	Emphysema	Phlebitis	Stroke
Rheumatic Fever	Tuberculosis	Blood Clot	Epilepsy/Seizure	
Previous Back/Neck Injury	Polio	Osteoporosis	Thyroid Disorder	

Other: _____ **NONE**

Height: _____ Weight: _____ Gender: M F Marital Status: S M W D

Do you use: Tobacco: Yes ___ No ___ Alcohol: Yes ___ No ___ Drugs: Yes ___ No ___

Family History: ☐ **Adopted**

(Please circle any conditions your family members have: items not circled are understood to be negative)

Abnormal Bleeding	Rheumatoid Arthritis	Bleeding Ulcer	Osteoporosis	Cancer
Ankylosing Spondystis	Bone Disease	Lupus	Gout	Hypertension
Heart Disease	Ulcerative Colitis	Crohns Disease	Stroke	Diabetes

Is there any other information you would like us to be aware of: _____
_____
_____

I verify that the above is an accurate representation of my past and current health. HIPPA ACKNOWLEDGEMENT: I also verify that I have received a copy of the Notice of Privacy Practices regarding the use and disclosure of my private health information.

Patient/Guardian Signature: _____Date_____