Date: ____________________

**Welcome to Our Practice**

Last Name: ____________________________________ First Name: ________________________ MI: __________

Address: _________________________________________ City: _________________ State: _____ Zip: __________

Home #: ___________________________ Alternate #: _____________________ May we leave a message? ☐ Y ☐ N

Social Security #: ______- ___- _______ Sex: ☐ Female ☐ Male ☐ Other

Date of Birth: ____ /_____ / _____ Marital status: □ Single □ Married □ Divorced □ Widowed

Employer: _____________________________________ Occupation: ______________________________________

E-Mail: _______________________________________ May we use your email for communication:☐ Y☐ N

Primary Care Physician: _________________________________ Phone #: ___________________________________

Referring Physician: ____________________________________ Phone #: ___________________________________

Preferred Pharmacy (Please list phone number and cross streets): ________________________________________

**Additional Parties Authorized to View Your Records**

Name: ________________________ Address: __________________________________ Phone#: _________________

Name: ________________________ Address: __________________________________ Phone#: _________________

**Someone to Contact in Case of Emergency**

Name: _______________________ Relationship to Patient: ___________ Home #: _______________ Alt #: ________

**Responsible Party: THE PERSON WHO SHOULD RECEIVE THE BILL**

Relationship to Responsible party: □Self □ Spouse □ Son □ Daughter □Other

Name: _________________________________ Date of Birth: _____ /_____/_______ Employer: __________________

Address: ___________________________________ City: _____________________ State: ________ Zip: ___________

Home #: _______________________________________ Alternate #: ___________________________________

**Primary Insurance**: _____________________________

Address: ______________________________________

City/State/Zip: _________________________________

Primary Insured Name: __________________________

ID/Policy #: ________________________ Suffix: ______

Group #: ______________ Employer: ________________

**Secondary Insurance**: __________________________

Address: ____________________________________

City/State/Zip: _______________________________

Primary Insured Name: _______________________

ID/Policy #: _________________ Suffix: __________

Group#: ___________________ Employer: ________

**I acknowledge that the above information is true:** ________________________________________ ________________

**Patient signature** **Date**

Name: ________________________________________

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## Medical History

**Reason for Today's Visit: ______________________________________________________________**

**Skin Disease Conditions**

Please Check all conditions that apply

| | | |
|---|---|---|
| ☐ Acne | ☐ Actinic Keratosis | ☐ Basal Cell Skin Cancer |
| ☐ Blistering Sunburns | ☐ Oral Herpes (Cold sores) | ☐ Eczema |
| ☐ Flaking or Itchy Scalp | ☐ Melanoma | ☐ Poison Ivy |
| ☐ Atypical Moles | ☐ Psoriasis | ☐ Squamous Cell Skin Cancer |

**Medical Conditions** Please check all conditions you currently have or have had in the past year

GENERAL
- ☐ Recent Fever/Chills
- ☐ Recent Weight Loss

EYES
- ☐ Eye Pain

ENDOCRINE
- ☐ Diabetes
- ☐ Thyroid Disease

CARDIOVASULAR
- ☐ Heart Disease
- ☐ Shortness of Breath
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Irregular Pulse
- ☐ Heart Murmur
- ☐ Leg Swelling

INFECTIOUS DISEASE
- ☐ HIV Positive
- ☐ Hepatitis
- ☐ AIDS

EAR, NOSE, THROAT AND MOUTH
- ☐ Balance Disturbance
- ☐ Vertigo/Spinning
- ☐ Nosebleeds

RESPIRATORY
- ☐ Asthma
- ☐ Emphysema
- ☐ Bronchitis

GASTROINTESTINAL
- ☐ Liver Disease
- ☐ Ulcers or Gastritis

GENITOURINARY
- ☐ Uterine/Cervical Cancer
- ☐ Prostate Cancer

BLOOD AND LYMPH
- ☐ Anemia
- ☐ Hemophilia
- ☐ Bleeding Tendencies
- ☐ Swollen Glands or Lymph nodes
- ☐ Blood Transfusion

NEUROLOGICAL
- ☐ Headache
- ☐ Loss of Consciousness
- ☐ Dizziness/Vertigo
- ☐ Poor Balance/Frequent Falling
- ☐ Seizures
- ☐ Paralysis
- ☐ Face Weakness
- ☐ Facial Pain
- ☐ Facial Spasm

PSYCHOLOGICAL
- ☐ Anxiety
- ☐ Depression

MUSCULOSCELETAL
- ☐ Back Pain
- ☐ Leg Pain
- ☐ Leg Weakness
- ☐ Neck Pain
- ☐ Arm Weakness
- ☐ Arthritis

Other: ______________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________

**Review of Systems**

Please check all that currently apply:

| | | | |
|---|---|---|---|
| General: | ☐ Fatigue | ☐ Unexpected weight changes | |
| Gastrointestinal: | ☐ Diarrhea | ☐ Nausea | ☐ Vomiting |
| Musculoskeletal: | ☐ Joint Pain | ☐ Muscle Aches | |
| Neurologic: | ☐ Dizziness | ☐ Headache | |
| Reproductive: | ☐ Pregnant | ☐ Planning Pregnancy | ☐ Breastfeeding |

Signature:_____________________________________________Date:______/____/_______

Name: ______________________________________

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## Family History

Do you have a family history of melanoma? ☐ Yes ☐ No

If yes, which relative(s)? ____________________________________________

List all other pertinent health information about your family: ____________________________________________

____________________________________________

____________________________________________

## Medications

List all medications and supplements you are currently taking: ____________________________________________

____________________________________________

____________________________________________

Do you require antibiotics prior to surgery? Yes No

## Allergies

List any known allergies and coinciding reactions, please include preparations or items used in office (example: latex gloves, Bacitracin, etc.): ____________________________________________

____________________________________________

## Hospitalizations/Surgeries

Please check all that apply: ☐ Heart Valve Replacement ☐ Joint Replacement ☐ Pacemaker/Defibrillator

List other surgeries/hospitalizations below:

| Year | Hospital | Reason |
|---|---|---|
| ________ | ____________________ | ____________________ |
| ________ | ____________________ | ____________________ |

## Sun Exposure

**Do you wear sunscreen**? ☐ Yes ☐ No If yes, what SPF? ___________

**Do you avoid the sun?** ☐ Yes ☐ No

**Do you tan in a tanning salon?** ☐ Yes ☐ No

**Do you have a history of blistering sunburns?** Yes ☐ No

## Health Habits

Circle Yes or No and List Amount

Alcohol ☐Yes ☐No ____________________

Caffeine ☐Yes ☐No ____________________

Tobacco ☐Yes ☐No ____________________

Drugs ☐Yes ☐No ____________________

**How were you referred to our office?** Please list the source below.

☐ Insurance Company Website: ____________________________________________

☐ Doctor: ____________________________________________

☐ Patient: ____________________________________________

☐ Other: (Example: Newspaper/Magazine Ad, Google, Yahoo, Dex Online, Yellow Pages):

____________________________________________

**Is your illness or injury related to any of the following?**

☐ Employment

☐ Emergency

☐ Accident

☐ Other: ____________________

If work related, please describe circumstances:

____________________________________________

____________________________________________

____________________________________________

## Ethnicity and Race

**Which one of the following groups best represents your race? (Check only one)** ☐ American Indian or Alaska Native ☐ Asian ☐ Native Hawaiian or Other Pacific Islander ☐ Black or African American ☐ White ☐ Hispanic ☐ Other Race

**Are you of Hispanic or Latino Background? (check only one)** ☐ Yes ☐ No ☐ Don't Know

**What is your preferred language?** ____________________________

Signature: ____________________________________________ Date: ______/____/_______

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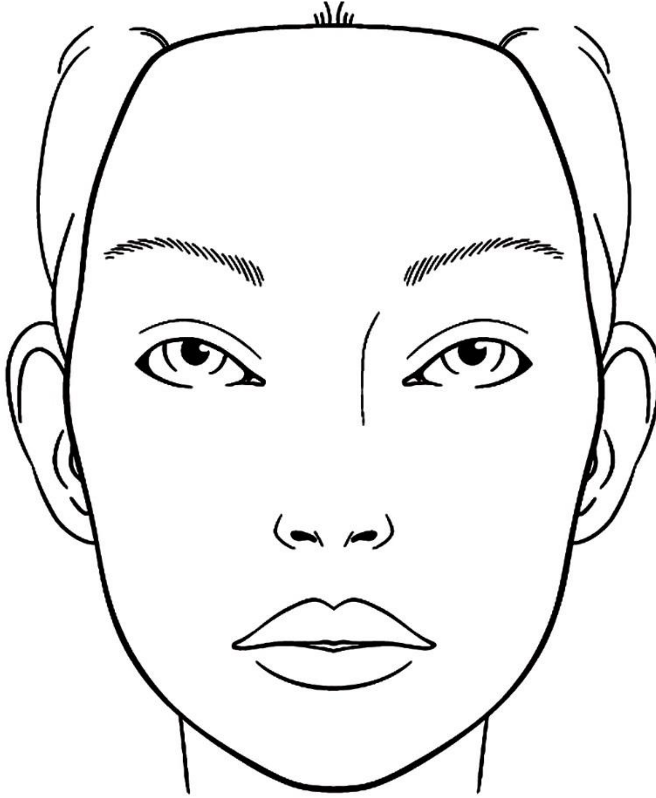
# COSMETIC SERVICES

Please put an **x** on the areas of concern:



Please check the procedures you are interested in learning more about:

___ Botox/Dysport

___ Filler

___ Kybella

___ Photofacial

___ Profractional

___ Laser hair removal

___ Chemical Peel

___ Microdermabrasion

___ Dermaplaning