NAME: (First, M.I., Last) ______________________________ **Date of Birth**: ________________

Preferred Name (Nickname, First or Last): ____________________ ☐ **Male** ☐ **Female**

Phone Numbers: Home: ________________ Cell: ________________ Work: ________________

Email Address: ____________________________

Primary Address: ______________________________ **City** ______________ **State** _____ **Zip** ________

Local Address: ______________________________ **City** ______________ **State** _____ **Zip** ________

Emergency Contact: Name __________________ Phone: ______________ Relationship ______________

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed ☐ Other

Patient's Occupation: _________________________ **Employer**: _____________________

Primary Care Physician __________________________ **Actual Caretaker (NP, PA)** ________________

PCP Location: __________________________________ **PCP Phone #:** __________________________

Other Physicians Actively Involved in Your Care:

Name: ____________________________ Specialty: ______________________ Phone: _____________

Name: ____________________________ Specialty: ______________________ Phone: _____________

How were you referred to us?

☐ Another Patient: _____________________ ☐ Physician: _______________________ ☐ Staff Member

☐ Ad/Announcement: _____________________ ☐ Internet, website? __________________ ☐ Yellow Pages

Have you consulted with other physicians? ☐ Yes ☐ No **Budget?** $________

MEDICAL HISTORY

ALLERGY TO MEDICATIONS: ☐ Please check here if None Known

Medication: ____________________________ Reaction(s): ☐ Rash ☐ Hives ☐ Breathing problem ☐ Anaphylactic Shock

Medication: ____________________________ Reaction(s): ☐ Rash ☐ Hives ☐ Breathing problem ☐ Anaphylactic Shock

Medication: ____________________________ Reaction(s): ☐ Rash ☐ Hives ☐ Breathing problem ☐ Anaphylactic Shock

Medication: ____________________________ Reaction(s): ☐ Rash ☐ Hives ☐ Breathing problem ☐ Anaphylactic Shock

LATEX ALLERGY? ☐ Yes ☐ No

USE OF ASPIRIN/IBUPROFEN/ANTI-INFLAMMATORY MEDS: ☐ Never ☐Occasional ☐ Regular/Daily

Last Used: ☐ Less than 2 weeks ago ☐ More than 2 weeks ago

CURRENT OR RECENT MEDICATIONS (*including* vitamins/supplements and over-the-counter drugs)

☐ Please check here if None

Medication: _________________________________ Dosage: ___________________________________

Medication: _________________________________ Dosage: ___________________________________

Medication: _________________________________ Dosage: ___________________________________

Medication: _________________________________ Dosage: ___________________________________

MEDICAL HISTORY (cont.)

All information will be kept confidential and as part of your medical records.

NAME: ________________________________ **DATE OF BIRTH:** ___________________ **AGE:** ___________

WHEN WAS YOUR LAST PHYSICAL EXAM? ☐ Never ☐ 6 mos- 1 yr ☐ 1-5 yrs ☐ > 5 yrs

HAVE YOU HAD ANY OF THE FOLLOWING:

☐ Heart Attack	☐ Asthma	☐ Cancer	☐ Diabetes
☐ Angina	☐ COPD	☐ Prostate Problems	☐ Thyroid Problems
☐ Stroke	☐ Emphysema	☐ Kidney Problems	☐ Recreational Drug Use
☐ Irregular Heartbeat	☐ Hiatal Hernia	☐ Hepatitis/Liver Problem	☐ Depression
☐ High Blood Pressure	☐ Gastric Reflux (GERD)	☐ Blood Transfusion	☐ Anxiety
☐ Circulation Problems	☐ Ulcers	☐ Exposure to HIV/ AIDS	☐ Bipolar Disorder
☐ Bleeding Problem	☐ Seizures	☐ Arthritis	☐ Schizophrenia
☐ Clotting Problem	☐ Psychiatric Problems	☐ Back/Neck Problems	☐ Polycystic Ovary Syndrome
☐ Phlebitis	☐ Skin Problems	☐ Easy Bruising	

GYNECOLOGICAL HISTORY:

DATE OF LAST PERIOD ___________

OF PREGNANCIES: __________ # OF DELIVERIES: __________

DESIRE ADDITIONAL PREGNANCIES ☐ Yes ☐ No

BREAST FED IN PAST? ☐ Yes ☐ No BREAST FEED IN FUTURE? ☐ No ☐ If possible ☐ Yes, Very Important

COSMETIC AND NON-COSMETIC PROCEDURES/HOSPITALIZATIONS:

Procedure/Reason:	Surgeon or Location/Hospital	Date

LIFESTYLE AND HABITS:

Alcohol Use: ☐ Never ☐ Rarely ☐ Social ☐ Daily **Recreational Drugs:** ☐ No ☐ Yes, ________________________

Have you ever smoked? ☐ No ☐ Yes, → Still Smoke? ☐ Yes ☐ No, → Quit Date_________

# of years Smoked: _________ # of packs/day: _________

Weight History: ☐ My weight is an issue ☐ Recent weight gain ☐ Recent weight loss ☐ Weight fluctuated >10lbs

☐ My weight is not an issue ☐ Weight has been stable for ________months _________ years

Approx Height ___________ **Approx Weight** ______ lbs **"Ideal" Weight** ______ lbs

Exercise: ☐ Never ☐ 1-2x/week ☐ 3-5x/week ☐ Daily

I understand that I am responsible for all charges. I will furnish this office with all information necessary to bill my insurance. Any balance after insurance has paid or denied is due by me. I agree that if it becomes necessary to forward my account to a collection agency, I will also be responsible for the reasonable cost of collection, to include attorney fees. I understand that my insurance benefits and referral requirements are my responsibility and that all co-payments are due at the time of service. _________ ***(initials)***

I authorize payment of medical benefits to physician for these services and all future claims and I authorize the release of any medical information necessary to process this claim and all future claims. _________ ***(initials)***

I understand that it is my obligation to obtain a referral for specialist services from my primary care physician prior to my appointment. I acknowledge that, if I do not have a referral at the time that services are provided, I will be responsible for payment for services received. _________ ***(initials)***

*I acknowledge that I am in receipt of the Notice of Privacy Practices*_________ ***(initials)***

____ _______________________________

Signature (Must be a parent or guardian for children 17 and under) **Date**

SKIN EVALUATION

What skin concerns would you like to discuss (check all that apply)

- ☐ Pigment
- ☐ Melasma
- ☐ Blood Vessels
- ☐ Anti-Aging
- ☐ Enlarged Pores
- ☐ Sun Damage
- ☐ Rosacea
- ☐ Wrinkles
- ☐ Acne
- ☐ Scarring
- ☐ Eczema
- ☐ Skin Laxity
- ☐ Uneven Tone/Texture
- ☐ Unwanted Hair Growth
- ☐ Psoriasis
- ☐ *Other*: ____

History of sun exposure (check all that apply)

- ☐ Sun Lover in the Past
- ☐ Actively Tanning
- ☐ Occasional Tan on Vacation
- ☐ Completely Committed to Sun Protection
- ☐ Moderately Committed to Sun Protection

History of skin cancer or pre-cancerous lesions? ☐ No ☐ Yes ____

History of acne? ☐ No ☐ In the Past ☐ Still a Problem

Have you ever been on the medication Accutane? ☐ No ☐ Yes, Last Used ____________________________

Retin- A use? ☐ No ☐ In the Past ☐ Currently Using

Use of Hormonal or Cellular Skin Cream? ☐ No ☐ Yes, When:____

Ever had a chemical peel?
☐ No ☐ Yes, When/Type:____

Ever had a laser treatment?

☐ No ☐ Yes, When/Type:____

Are you currently waxing, bleaching or using depilatories, or using electrolysis? ☐ No ☐ Yes, ______________

What Skin Care Products Are You Using?
____

____

Have you had any Cold Sores/ Fever Blisters? ☐ No ☐ Yes

Have you ever been treated for any of the following:

- ☐ Acne
- ☐ Psoriasis
- ☐ Shingles
- ☐ Cold Sores
- ☐ Keloid
- ☐ Skin Cancer
- ☐ Melanoma
- ☐ Polycystic Ovarian Syndrome
- ☐ AIDS
- ☐ Hirsutism
- ☐ Vitiligo
- ☐ Skin Pigmentation Problem
- ☐ Hives
- ☐ STDs
- ☐ Port Wine Stain or Hemangioma

Have you used any of the following in the *last 6 weeks*?

- ☐ Retin–A
- ☐ Renova
- ☐ Retinol
- ☐ Alpha-Hydroxy Acid
- ☐ Lactic Acid
- ☐ Glycolic Acid