PATIENT HISTORY

Today's date: ________________
Name: ____
Address ____
City ______________________________ State_____________ Zip _____________
Preferred Contact Number: ☐ Home ☐ Work ☐ Cell
Email Address: ____
Phone #_________________________________
May we leave a detailed message at this number? ☐Yes ☐ No

Personal Information
Date of Birth: ______________________________ Age_________ Gender: ☐ Female ☐ Male
Emergency Contact: ________________________________ Phone: ___________________________
Marital Status_______________________________ Occupation ______________________________

What Services Do You Want To Learn About?
_____Minimize Wrinkles & Skin Rejuvenation Lines
_____Longer Natural Eye Lashes
_____Facial Discoloration Treatment
_____Age Spots / Melasma / Pigmentation Over All Skin Care
_____Medical weight Loss
_____Laser Hair Removal
_____Tattoo Removal
_____Minimize Acne or Break-Outs Acne Scars
_____Problem with Erectile Dysfunction
_____Problem with Libido, Incontinency, Vaginal Dryness
_____Hormone and Fatigue management

How Did You Find Us? (Mark all that apply)
_____Internet
_____Facebook
_____Living Social / Groupon PrideGuide
_____Radio
_____Television
_____Walking By

Previous Cosmetic or invasive or non-invoices fat removal or weight loss Treatments:
Botox ® Date: __________,
Dysport Date: __________,
Dermal Fillers: Date: __________,
Cosmetic Surgery: Date: __________
Micrneedling: Date: __________
Hormonal Replacement therapy (Bio Identical Hormones): Date: _____________
Plasma Injection (Vampire facial, facelift, o'shots, p'shots): Date: ______________

Patient's Initial __________

Medical HISTORY (*please circle all that apply*)
Do you have a history of **herpes** I or II in the area to be treated? Yes No
Do you have a history of **keloid** scarring? Yes No
Have you taken **Accutane** or anticoagulants in the last 6 months? Yes No
Have you taken **Anticoagulants** in the last 6 months? Yes No
Do you have a history of **Melasma**? Yes No
Do you have a history of **scleroderma**? Yes No
Do you have a history of **collagen vascular disease**? Yes No
Do you have a history of **clotting disorders**? Yes No
Do you have a history of **active infection**? Yes No
Do you have **immunosuppression**? Yes No
Have you taken **Accutane** or anticoagulants in the last 6 months? Yes No
Have you taken **Anticoagulants** in the last 6 months? Yes No
(For women) Are you or could you be **Pregnant** or **Nursing** mother (Breastfeeding)? Yes No

General	**Head / Ears / Nose / Throat**	**Pulmonary**	**Metabolic**
Unplanned Weight Change Fevers/Chills Fatigue	Visual Problems Glasses / Contacts Cataracts Hearing Problems Sinus problem Neck pain Thyroid Problem	Cough Wheezing Shortness of Breath Positive TB Asthma	Diabetes Hypertension High Cholesterol
Cardiac	**Gastrointestinal**	**Genitourinary**	**Psychological**
Irregular Heart Beat Palpitations Heart Failure Rheumatic Fever Heart Surgery	Abdominal Pain Trouble Swallowing Nausea/Vomiting Dark / Black Stool Diarrhea Constipation Bright Red Blood in Stool Stomach Ulcers	Blood in Urine Prostate Problems Discomfort-Urination Incontinency	Depression Anxiety Alcoholism Street drug use

Patient's Initial ___________

Hematological	Neurological	Musculoskeletal	Gynecologic
Abnormal Bleeding Easy Bruising Blood Clots in Legs/Lungs HIV, AIDS Nose Bleeds Hepatitis B Hepatitis C	Headaches Dizziness Passing Out Seizure / Epilepsy Stroke Bell's Palsy Trigeminal Neuralgia	Swelling in Extremities Leg Ulcers Varicose Veins	Breast Pain Breast Discharge Menopause Hysterectomy **Skin** Rash Herpes (Genital, Coldsore) Shingles

List **ALL** prescriptions and over-the-counter medications presently using:
____
____
____
____
____
____

List **ALL DRUG,** food, latex or other substances allergies:
____
____
____

List **ALL** surgeries and dates:
____
____
____
____

Family Medical History (please check all that apply)

Heart Disease/Stroke	Diabetes
High Cholesterol	Obesity
High Blood Pressure	Cancer

Other____
____

Patient's Initial ___________