

Name: _____ Birth Date: ____/____/____ Age: _____
Address: _____ Sex: M / F
City: _____ State: ____ Zip Code: _____
Home: (____) _____ Work: (____) _____ Cell: (____) _____
E-mail: _____
Emergency Contact: _____ Telephone: (____) _____
Allergies: _____
For women: LMP: _____
How did you hear about {Practice Name Here}? _____

Please put a check mark next to the procedures about which you would like to receive more information:

- | | |
|---|---|
| <input type="checkbox"/> Acne Treatment | <input type="checkbox"/> Brown Spots |
| <input type="checkbox"/> Botox® to Flatten and Prevent Wrinkles | <input type="checkbox"/> Sun Damage |
| <input type="checkbox"/> Enhanced Skin Rejuvenation | <input type="checkbox"/> Broken Capillaries |
| <input type="checkbox"/> Collagen Augmentation | <input type="checkbox"/> Spider Veins/Leg Veins |
| <input type="checkbox"/> Wrinkles | <input type="checkbox"/> Hair Reduction |
| <input type="checkbox"/> Skin Toning or Pore Size Reduction | <input type="checkbox"/> Shaving bumps/ingrown hair |
| <input type="checkbox"/> Facial Redness | <input type="checkbox"/> Restilyne® |

Please put a check mark next to a past or current medical condition:

Medical History:

- | | |
|--|---|
| <input type="checkbox"/> Lupus or other auto-immune deficiency(A) | <input type="checkbox"/> Herpes simplex or fever blisters (A) |
| <input type="checkbox"/> Rheumatoid Arthritis "Gold" Therapy (A) | <input type="checkbox"/> Diabetes (A) |
| <input type="checkbox"/> Currently Pregnant (A) | <input type="checkbox"/> Light sensitive Epilepsy (A) |
| <input type="checkbox"/> Bleeding abnormalities (A) | <input type="checkbox"/> Scars that turn white or brown (A) |
| <input type="checkbox"/> Treatment with Accutane® in the last year (A) | <input type="checkbox"/> Dark spots after pregnancy, skin injury (A) |
| <input type="checkbox"/> Treatment with Tetracycline® in the last month(A) | <input type="checkbox"/> HIV (A) |
| <input type="checkbox"/> Keloid or very thick scarring (A) | <input type="checkbox"/> Hepatitis (A) |
| <input type="checkbox"/> Psoriasis or Vitiligo (A) | <input type="checkbox"/> Waxing/Plucking/Electrolysis within last four weeks (HR) |
| <input type="checkbox"/> Pulmonary embolism/blood clot (V) | <input type="checkbox"/> Hirsutism (HR) |
| <input type="checkbox"/> Leg ulcer or Phlebitis (V) | <input type="checkbox"/> Transplant Anti-Rejection Drugs (HR) |
| <input type="checkbox"/> Blood thinning medication (V) | <input type="checkbox"/> Chemical Peels, Dermabrasion, Laser Resurfacing or Face Lift (A) |
| <input type="checkbox"/> Coumadin®/anti-clotting agents (A) | <input type="checkbox"/> Tattoos/permanent make-up (A) |
| <input type="checkbox"/> Cystic Acne (P) | <input type="checkbox"/> Polycystic ovarian disease (PCOD) |
| | <input type="checkbox"/> Implants (Location:_____) |
| | <input type="checkbox"/> Collagen injection (Location:_____) |

Please list any medications or herbal supplements that you are currently taking: _____

Patient Signature

Date