PATIENT REGISTRATION & HEALTH QUESTIONNAIRE

PATIENT INFORMATION

Name: ____ Date of Birth: ____________
First Middle Last

❏ Male ❏ Female ❏ Other_______________ Social Security Number: _____-_____-_____

❏ Single ❏ Married ❏ Other: _____________Driver's License:___________ ________
Number State

Legal Guardian or responsible party (if different from above): ______________________________

Home Address: ______________________________________
Street
____
City State Zip

Billing Address: C/O_________________________
(If different)

_____________________________ Occupation: ___________________________
Street
_____________________________ Employer: ___________________________
City State Zip

❏ Home Phone: ( ) ____________ ❏ Mobile: ( ) ____________ ❏ Office: ( ) ____________

Please mark (check box) which of the above numbers is your preferred contact to reach you, confirm appointments or leave messages.

❏Email Address: _________________________

Do we have your consent to communicate with you by e mail regarding lab results, prescription refills or other non urgent matters?

______YES _____NO

Emergency Contact:

____
Name Telephone Relationship

REFERRAL INFORMATION

How did you hear about our office?

❑ Referred by another physician ______________________________
Name

❑ Referred by another patient ________________________________
Name

❑ Referred by affiliated industry (facialist/hair salon, etc.): ____

Internet Search: ❑ Google ❑ Yelp Other: ______________________

❑Insurance Directory (which company?): _____________________________

❑ Other: ______________________________

MEDICAL HISTORY

Do you have any history of:

Yes	No	Condition
❑	❑	Artificial Joints?
❑	❑	Heart Disease?
❑	❑	Liver Disease/Hepatitis?
❑	❑	Bleeding Problems?
❑	❑	Difficulty Healing Wounds?
❑	❑	Depression/Anxiety or Bipolar Disorder?
❑	❑	Fever Blisters?
❑	❑	Thyroid Disease?
❑	❑	Immune Deficiency/HIV?
❑	❑	Family History of Skin Disease or Skin Cancer? (If yes, explain below)
❑	❑	Heart Murmur?
❑	❑	Artificial Heart Valve?
❑	❑	Pacemaker?
❑	❑	High Blood Pressure?
❑	❑	Diabetes? ____T1 ____T2
❑	❑	Non skin Cancer? (Explain below)
❑	❑	Rheumatic Fever
❑	❑	Keloids
❑	❑	Kidney Disease
❑	❑	Blood Clots
❑	❑	Glaucoma
❑	❑	Require Antibiotics before medical/dental Procedures? If yes, why? ____________________________
❑	❑	Allergy or sensitivity to anesthetic agents?
❑	❑	Prior Cosmetic Procedures: ____

Additional information for “yes” answers: ____

____

____

CURRENT MEDICATION/DRUG ALLERGIES: include dietary supplements, aspirin, and birth control pills

Current Medication/Dosage	Cont - Current Medications/Dosage	Drug Allergies
1. ____________________	4. ____________________	1. ____________________
2. ____________________	5. ____________________	2. ____________________
3. ____________________	6. ____________________	3. ____________________

Other Medications: ____

____

DERMATOLOGIC HISTORY

1. Is there a history of melanoma in your immediate family? ❑ Yes ❑ No If yes, who? ___________________
2. Do you have a history of severe sunburn(s) as a child or a teen? ❑ Yes ❑ No
3. Do you regularly sunbathe or visit tanning salons? ❑ Yes ❑ No
4. Do you regularly apply sunblock to exposed areas? ❑ Yes ❑ No If yes which SPF? ___________
5. Do you or anyone in your family have a history of any skin disease? (rashes, eczema, psoriasis, etc.) ❑Yes ❑ No
   If yes, please explain ____

   ____

TODAY'S VISIT

What is the primary reason for your visit today?

❑Changing Mole/Skin Growth

❑ Full Body Check/Skin Cancer Screening ❑ Other __________________

❑Acne

❑Rash
❑Hair Loss
❑Cosmetic: (check all that apply) ___Botox ___Filler ___Laser Rosacea or Spider Veins ___Laser Freckles

___Laser Tattoo Removal ____Laser for fine lines/ skin laxity

❑Other ____ ___________

PHARMACY INFORMATION— PROVIDE ALL INFORMATION FOR PRESCRIPTIONS TO BE FILLED

______________________ ___________________________ ______________________________
Pharmacy Name Address (or intersection) Phone

_____________________________ __________________________
Patient Signature **Date**