PATIENT REGISTRATION & HEALTH QUESTIONNAIRE

PATIENT INFORMATION

Name: ____ Date of Birth: ______________
First Middle Last

❑ Male ❑ Female 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	Yes	No	Yes	No
❑	❑ Artificial Joints?	❑	❑ Family History of Skin Disease or Skin Cancer? (If yes, explain below)		
❑	❑ Heart Disease?				
❑	❑ Liver Disease/Hepatitis?	❑	❑ Heart Murmur?	❑	❑ Rheumatic Fever
❑	❑ Bleeding Problems?	❑	❑ Artificial Heart Valve?	❑	❑ Keloids
❑	❑ Difficulty Healing Wounds?	❑	❑ Pacemaker?	❑	❑ Kidney Disease
❑	❑ Depression/Anxiety or Bipolar Disorder?	❑	❑ High Blood Pressure?	❑	❑ Blood Clots
❑	❑ Fever Blisters?	❑	❑ Diabetes? ____T1 ____T2	❑	❑ Glaucoma
❑	❑ Thyroid Disease?	❑	❑ Non skin Cancer? (Explain below)	❑	❑ Taken Medicine Accutane
❑	❑ Immune Deficiency/HIV?				

❑ ❑ Require Antibiotics before medical/dental Procedures? If yes, why? ____________________________________

❑ ❑ Any complications with previous surgeries? ____

❑ ❑ 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 ____ ___________

_______________________________ ___________________________
Patient Signature **Date**