



PATIENT REGISTRATION & HEALTH QUESTIONNAIRE

PATIENT INFORMATION

Name: _____ Date of Birth: _____
First Middle Last

Male Female Other: _____

Single Married Other: _____

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

Mailing Address: _____
Street

City State Zip

Billing Address: C/O _____
(If different)

Street Occupation: _____

City State Zip Employer: _____

Mobile: () _____ Other: () _____

Our office uses automated texts to mobile numbers for appointment confirmations. _____

INITIALS

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.): _____

Online/Other: Google Yelp Other: _____

MEDICAL HISTORY

Do you have any history of:

Yes No

- Artificial Joints
- Heart Disease
- Liver Disease/Hepatitis
- Bleeding Problems
- Difficulty Healing Wounds
- Depression/Anxiety/Bipolar Disorder
- Fever Blisters
- Thyroid Disease
- Require Antibiotics before medical/dental Procedures? If yes, why? _____
- Allergy or sensitivity to anesthetic agents?
- Prior Cosmetic Procedures: _____

Yes No

- 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)

Yes No

- Rheumatic Fever
- Keloids
- Kidney Disease
- Blood Clots
- Glaucoma
- Immune Deficiency/HIV

Additional information for "yes" answers: _____

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

Current Medication/Dosage

1. _____
2. _____
3. _____

Cont - Current Medications/Dosage

4. _____
5. _____
6. _____

Drug Allergies

1. _____
2. _____
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 _____
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TODAY'S VISIT

What is the primary reason for your visit today?

- Changing Mole/Skin Growth
- Full Body Check/Skin Cancer Screening
- 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