PATIENT REGISTRATION & HEALTH QUESTIONNAIRE

PATIENT INFORMATION

Name: ____ Date of Birth: __________

First Middle (Maiden) 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: ________________________________ Occupation: ________________________

(If different from above) Street

________________________________ Employer: ________________________

City State Zip

❑ Email Address: ________________________

❑ Home Phone: ( ) ____________ ❑ Mobile: ( ) ____________ ❑ Work: ( ) ____________

Please indicate which of the above methods (use check box) is best for contacting you with automated appointment reminders or leaving you other messages regarding your visit.

Emergency Contact:

____

Name Telephone Relationship

REFERRAL INFORMATION

How did you hear about our office?

❑ Referred by another physician

____

Name Telephone

❑ Referred by another patient

____

Name

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

❑ Google ❑ Yelp ❑ Facebook

❑ Insurance Directory (which company?): ______________ ❑ Website/Other: ______________

MEDICAL HISTORY

Do you have any history of:

Yes	No		Yes	No		Yes	No	
❑	❑	Artificial Joints	❑	❑	Family of Bleeding Problems	❑	❑	Heart Disease
❑	❑	Liver Disease/Hepatitis	❑	❑	Heart Murmur	❑	❑	Rheumatic Fever
❑	❑	Bleeding Problems	❑	❑	Artificial Heart Valve	❑	❑	Keloids
❑	❑	Difficulty Healing Wounds	❑	❑	Pacemaker:_______________	❑	❑	Kidney Disease
❑	❑	Emotional Disorders	❑	❑	High Blood Pressure	❑	❑	Blood Clots
❑	❑	Fever Blisters	❑	❑	Diabetes	❑	❑	Glaucoma
❑	❑	Thyroid Problems	❑	❑	Cancer: (type)_______________	❑	❑	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. ____________

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 brand/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______________________________
6. What is your current skin care regimen? (brand and products)______________________________

TODAY’S VISIT

1. **What is the primary reason for your visit today? (Check all that apply)**

   ❑ Acne ❑ Rash ❑ Hair loss ❑ Cosmetic (Fillers / Botox / Laser Procedures, etc.)

   ❑ Changing Mole/Skin Growth ❑ Full Body Check/Skin Cancer Screening ❑ Other ________________

2. **Are you interested in learning more about any of the following procedures we also offer?**

   ❑ Dermal Fillers Restylane/Juvederm ❑ Botox ❑ Latisse Eyelash Solution

   ❑ Sclerotherapy (leg veins) ❑ Hair Loss ❑ Chemical Peels ❑ Skin Care

   ❑ Fraxel Laser Resurfacing ❑ Laser Tattoo Removal ❑ Photofacial/IPL ❑ Other Laser Treatments

   ❑ Skin Cancer Surgery ❑ Other ______________________________

______________________ ____________

Patient Signature **Date**