Patient Name:	DOB:	Today's Date:
Address:	City:	State: Zip Code:
Phone:	Social Security:	PCP:
Preferred Language:	Ethnicity:	Race:
Marital Status:	Height:	Weight:
Email Address:	Would you like to be on our email list for special events and pricing?	[ ] Yes [ ] No
Emergency Contact:	Relationship:	Phone:
Preferred Pharmacy:	Phone:	Address:

Select any of the following medical conditions that you currently have or have had:

□None	□Coronary Artery Disease	□HIV/AIDs	□Breast Cancer
□Anxiety Disorder	□Depression	□High Cholesterol	□Colon Cancer
□Arthritis	□Diabetes	□Hyperthyroidism	□Prostate Cancer
□Asthma	□High Blood Pressure	□Hypothyroidism	□Radiation Therapy
□Atrial Fibrillation	□End Stage Renal Disease	□Hepatitis	□Bone Marrow Transplant
□Benign Prostatic Hyperplasia	□Epilepsy	□Leukemia	□Other:
□Cerebrovascular Accident	□GERD	□Lymphoma	
□COPD	□Hearing Loss	□Lung Cancer	

Select any of the following surgeries you have had:

□None	□Cholecystectomy	□Pancreatectomy
□Abdominoperineal Resection	□Colectomy	□Kidney Stone
□Bilateral Knee Replacement	□Liver Excision	□Portosystemic Shunt Operation
□Biopsy: Breast	□PTCA	□Prostatectomy
□Biopsy: Prostate	□Tissue Graft Heart Valve Replacement	□Hip Replacement
□Coronary Artery Bypass Graft	□Cystectomy	□Splenectomy
□Kidney Transplant	□Transurethral Prostatectomy	□Biopsy: Skin
□Excision: Basal Cell Carcinoma	□Hysterectomy	□Nephrectomy
□Excision: Melanoma	□Kidney Biopsy	□Orchidectomy
□Excision: Squamous Cell Carcinoma	□Low Anterior Resection of Rectum	□Joint Replacement: Hip Left Right (Circle One)
□Colostomy	□Lumpectomy: Breast Left Right Both (Circle One)	□Joint Replacement: Knee Left Right (Circle One)
□Tubal Ligation	□Mastectomy: Breast Left Right (Circle One)	□Heart Transplant
□Appendectomy	□Mechanical Heart Valve	□Liver Transplant
□Mastectomy	□Oophorectomy	□Other:

Select any of the following skin conditions you currently have or have had:

□None	□Dysplastic Nevus/Precancerous Moles	□Psoriasis
□Acne	□Eczema	□Squamous Cell Carcinoma
□Actinic Keratosis	□Asthma	□Sunburn
□Asteatosis Cutis	□Hay Fever/Allergies	□Other
□Basal Cell Carcinoma	□Melanoma: _____	
□Contact Dermatitis: Poison Ivy	□Pruritus of Scalp	

Do you wear sunscreen	YES	NO	If yes, what SPF?
Do you tan in a tanning salon?	YES	NO	
Do you have a family history of melanoma?	YES	NO	If yes, which relative?

PLEASE COMPLETE BOTH SIDES OF FORM

Please list the medications you take:

Name	Dose	How Often		Name	Dose	How Often

Do you pre-medicate with antibiotics before procedures?	YES	NO	
Do you take blood thinners?	YES	NO	Name:

List any allergy to medication: _____

What type of reaction do you have? _____

Social History (over 12):

□Current every day smoker	□Current some day smoker	□Former smoker	□Never smoker
Do you drink alcohol? □Yes □No	If yes: □less than 1 drink per day	□1-2 drinks per day	□more than 3 drinks per day
How many times in the past year have you had 5 or more drinks in a day? _____			

Vaccination Status; Have you received the following:

□ Flu Vaccine When: _____	□ Shingles vaccine (over 50)	□ Pneumonia vaccine (over 65)	□Age 9-13: A series of 3 HPV (Human Papillomavirus)

Advance Care (over 65):

Do you have a health proxy in the event you are unable to make your own medical decision? □Yes □No
Designee's name: _____ Designee's phone number: _____

Do you have a living will? □Yes □No
Which statement reflects your wishes on advanced care recommendations?

- □ Do Not Intubate: I do not wish to have a breathing tube, even if it is necessary to save my life.
- □ Do Not Resuscitate: If my heart were to stop, I do not wish to have chest compressions or an automated external defibrillator to restart my heart, even if it is necessary to save my life.
- □ Full Cardiopulmonary Resuscitation: I want full cardiopulmonary resuscitation efforts to be made.

Cosmetic products and health issues that are of interest to you (please check all that apply):

[ ] Botox or neurotoxin for wrinkles
[ ] Chemical peels
[ ] Retin A or retinol
[ ] Collagen therapy
[ ] Dermal fillers for wrinkles
[ ] Skin rejuvenation
[ ] Medical grade facials
[ ] Microdermabrasion
[ ] Dermal infusion
[ ] Removal of facial veins
[ ] Removal of moles
[ ] Excessive sweating
[ ] Wrinkles
[ ] Acne and/or acne scarring
[ ] Sunspots/uneven pigmentation
[ ] Laser photo-facial
[ ] Laser hair removal
[ ] Hydra facial
[ ] Skin care products
[ ] Sunscreen advice
[ ] Skin tightening
[ ] Anti-aging treatments
[ ] Scar or keloid removal
[ ] Earlobe repair
[ ] Spider leg veins
[ ] Micro-needling
[ ] Body contouring

Patient Signature: _____ Date: _____

PLEASE COMPLETE BOTH SIDES OF FORM