PATIENT HEALTH HISTORY

Full Name (Last, First, MI, "Nickname") _____ **Date of Birth** / / **Birth Sex** M / F **Race(s)** _____ **Today's Date:** / /

Email _____ **Height:** _____ **Weight:** _____

Phone Numbers *Provide your contact number(s) and check the box below for your preferred contact number.*

☐ **Mobile** _____ ☐ **Home** _____ ☐ **Work** _____

May we leave a detailed message? ☐ **Yes** ☐ **No**

Home Address _____ **City** _____ **State** _____ **Zip Code** _____

Emergency Contact (Last, First) _____ **Phone** _____

Pharmacy Name _____ **Pharmacy Address** _____ **Phone** _____

Primary Care Provider - PCP (First & Last Name) _____ **Phone** _____

☐ *Check if you do not have a PCP*

Referring Provider (First & Last Name) _____ **Phone** _____

☐ *Check if PCP is same as Referring Provider*

MEDICAL HISTORY

Select past and present medical conditions you have experienced:

☐ **None**
☐ Anxiety
☐ Arthritis
☐ Asthma
☐ Atrial Fibrillation *(Irregular Heartbeat)*
☐ Bone Marrow Transplantation
☐ Depression
☐ Diabetes
☐ Hepatitis
☐ Herpes
☐ HIV / AIDS
☐ Hirsutism
☐ Hypertension *(High Blood Pressure)*
☐ Hyperthyroidism
☐ Hypothyroidism
☐ PCOS
☐ Shingles
☐ Stroke

Cancers Other Than Skin: *Include type/location and treatment(s)* _____

Additional Medical Conditions: _____

PAST SURGERIES

☐ **None OR List all past surgeries:** _____

SKIN DISEASE HISTORY

☐ **None** If you have had any of the following skin conditions, provide details below *(including treatment dates and location(s))*:

SKIN CANCERS

☐ Basal Cell Carcinoma _____
☐ Melanoma _____
☐ Precancerous Moles _____
☐ Squamous Cell Carcinoma _____

SKIN CONDITIONS

☐ Acne _____
☐ Cold Sores/Fever Blisters _____
☐ Dry Skin _____
☐ Eczema _____
☐ Psoriasis _____
☐ Rosacea _____
☐ Vitiligo _____

☐ Additional Skin Conditions: _____

Do you wear Sunscreen? ☐ Yes ☐ No If yes, what SPF? _____ **Tanning salon usage?** ☐ Yes ☐ No

Do you have a family history of Melanoma? ☐ Yes ☐ No If yes, which relative(s)? _____

MEDICATIONS

List all medication names and dosages including prescription creams, over the counter, herbal supplements, and skin care products.

☐ **No current medications**

PATIENT HEALTH HISTORY

Full Name (Last, First, MI, "Nickname") _____ **Date of Birth** ___/___/___ **Today's Date:** ___/___/___

ALLERGIES

List all allergies and reaction(s), including medication, food, and environmental.

☐ **No known allergies**

_____

_____

SOCIAL HISTORY

TOBACCO USAGE

☐ Never ☐ Former ☐ Current If a smoker, number of packs per day: _____ Total years smoking: _____ Tobacco Type: _____

ALCOHOL USAGE

How many times in the past year have you had 5 or more drinks in a day for men, or 4 or more drinks in a day for women?

Number of Days _____ ☐ None ☐ Decline to Specify

OCCUPATION: _____

VACCINATION

Have you received an **Influenza Flu Shot** since August 1, 2019? ☐ Yes ☐ No

If no, please provide the reason: _____ ☐ Decline to Specify Reason

AGE 65+ ONLY (SKIP THIS SECTION IF YOUNGER THAN 65)

Do you have an **advance care plan/living will**? ☐ Yes ☐ No ☐ Decline to specify *(If no or decline, skip next two questions)*

Do you have a healthcare proxy? ☐ Yes ☐ No Designee's Name/Phone Number: _____

Which statement(s) reflect your wishes: ☐ Do not intubate ☐ Do not resuscitate ☐ Full cardiopulmonary resuscitation

Have you ever received a **pneumonia vaccination**? ☐ Yes ☐ No

Year of most recent pneumonia vaccination: _____ Vaccination(s) received (check all that apply): ☐ PPSV23 ☐ PCV13 ☐ Unsure

REVIEW OF SYSTEMS

Have you experienced any of these symptoms in the past week:

☐ **None** ☐ Fever/chills ☐ Rash ☐ Joint pain

ALERTS

Select all that apply:

☐ **None**
☐ Allergy to lidocaine
☐ Latex allergy
☐ Blood thinners
☐ Pacemaker
☐ Rapid heartbeat / sensitivity to epinephrine
☐ Pregnancy or planning a pregnancy
☐ Problems with healing
☐ Problems with scarring *(hypertrophic or keloid)*
☐ Immunosupression
☐ Breastfeeding
☐ Thyroid problems
☐ Diastasis Recti
☐ History of hernia or hernia repair
☐ Kidney disease
☐ Lupus
☐ Organ transplant
☐ History of tanning bed usage
☐ Tattoos
☐ Metal or other implants
☐ Hormone Replacement Therapy (HRT)
☐ Burns/skin graft
☐ Liver disease
☐ Isotretinoin (Accutane)
☐ Permanent makeup

ADDITIONAL QUESTIONS

How did you hear about us? _____ ☐ Referring Provider

Have you had any previous laser or skin treatments? _____

Which of the following concerns do you have about your skin/body?

☐ Aged skin
☐ Acne
☐ Redness
☐ Leg veins
☐ Sun damage
☐ Enlarged pores
☐ Wrinkles
☐ Hair removal
☐ Rosacea
☐ Whiteheads
☐ Oily skin
☐ Age spots
☐ Skin texture
☐ Melasma
☐ Cellulite
☐ Spider veins
☐ Scars
☐ Uneven skin color
☐ Pigment changes
☐ Dry skin
☐ Sweat/odor
☐ Sensitive skin
☐ Skin laxity
☐ Stubborn fat or pinchable fat
☐ Other:

Which of the following services would you like to learn more about?

☐ Laser skin rejuvenation
☐ Laser vein treatment
☐ Laser hair removal
☐ Rosacea treatment
☐ Sun damage repair
☐ Botox
☐ Acne treatment
☐ Age spot treatment
☐ Skin tightening
☐ Pigment treatment
☐ Wrinkle treatment
☐ Scar treatment
☐ Filler injections
☐ Redness/vessel
☐ Skin resurfacing
☐ Melasma
☐ MiraDry sweat and odor reduction
☐ Fat Reduction
☐ Other: