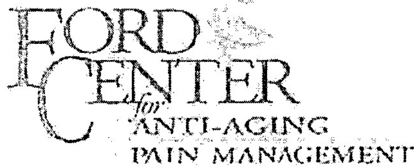

Welcomes you...

Please provide the following information so we may better serve you.

Your legal name ______________________________ Today's Date __________
(First) (Middle) (Last)

What name should we call you? ________________ Birth Date ____________

Are you: male or female Are you: single , married or other __________

Home address: ______________________ City ___________ State & zip _______

Home phone ________________ cell phone ______________ work phone_________

Please circle the above phone number where we should contact you.

Do you permit us to leave a message for you at the above number? Yes or No

Email____________ employer: _____________________ occupation ____________

Spouse's name ________________________ Do you authorize us to discuss your information with your spouse if they call? Yes or No

Please list an emergency contact who does not live with you ____________________

Relationship _____________ home phone _____________ cell phone ___________

Please indicate which concerns you might want to improve:

- ☐ fine lines around eyes
- ☐ drooping corners of mouth
- ☐ laser skin resurfacing
- ☐ laser micropeel
- ☐ age or sun spot removal
- ☐ hyperbaric oxygen therapy
- ☐ desire to quit smoking
- ☐ lines around lips
- ☐ laser hair reduction
- ☐ removal of skin lesions
- ☐ skin care regimen
- ☐ mole or skin tag removal
- ☐ tired-looking eyes
- ☐ uncontrolled appetite
- ☐ forehead creases
- ☐ nasal wolf lines
- ☐ scar revision
- ☐ laser vein therapy
- ☐ laser photo facial
- ☐ skinny lips
- ☐ weight gain

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Medical History

Family History:

Mother's Age ________ Health Problems ____________________________

Father's Age __________ Health Problems ____________________________

Number of sibling's _____ Health Problems ____________________________

Social History: Single _____ Married ______ Widowed _____ Divorced ______

Occupation: ____

Out of Work? Yes___No ___ Disability? Yes ___ No ___Retired? Yes ___ No __

PLEASE CHECK ALL THAT APPLY TO YOUR HEALTH.......

ARE YOU PRESENTLY ON A BLOOD THINNER: Yes ________ No ________

HEART: Heart Trouble _____ Heart Murmur ___ High Blood Pressure____
Chest Pain ____Heart Attack _____ Palpitations ______ Leg Swelling ______
Pace-Maker _______

LUNGS Cough _____Wheezing _____Asthma _____ Bronchitis _____ COPD ______

Pneumonia ______ TB _______ Sputum Color (yellow, brown, blood) ______

EYES Glasses/Contacts _______ Pain ______ Excessive Tearing ______
Double Vision ______ Glaucoma _______ Cataracts _______

EARS Ringing in Ears ______ Dizziness ______ Earaches _______ Infection ______
Drainage ______ Difficulty Hearing ______ Hearing Impaired ______
Hearing Aid (L___R___)

NOSE & SINUS Frequent Colds ____ Nasal Stuffiness _____Hay Fever Nosebleed _____
Sinus Trouble (explain) ____

MOUTH & THROAT Bleeding Gums ____ Sore Tongue ____ Sore Throat ___ Hoarseness ____

SKIN Rashes ______ Lumps ______ Itching ______ Drying ______ Color Change ___
Sensitive Skin ______ Change in Hair/Nails ______

HEAD Headache ______ Head Injury ______

NECK Lumps ______ Pain ______ Swelling ______

GASTRO- Trouble Swallowing ____ Heartburn _____ Ulcer ______ Nausea ______
INTESTINAL Constipation ____ Diarrhea _____ Hemorrhoids _____ Hepatitis ____
Jaundice ________ Gallbladder _______

ENDOCRINE Diabetes ________ Thyroid Disorder _______

KIDNEYS & Frequent urination at night ______ Pain during urination _______
BLADDER Frequent urge for urination ______ Unable to control bladder ______
Diagnosis of infection ______ Kidney stones ______

FEMALES Menstrual Problems ___ Pelvic Inflammatory Disease ___ Menopause__
ONLY Sexually Transmitted Disease ______

MALES Testicular Pain/Masses ______ Prostate Problems ______ Hernia ______
ONLY Sexually Transmitted Disease ______

MUSCULOSKELETAL Muscle Pain ___ Muscle Cramps ____ Artificial Joints ____
Gout ____ Joint/Pain Stiffness ____ Backache ____ Arthritis ____

VASCULAR Leg Pain __ Leg Cramps ___ Varicose Veins ___ Thrombophlebitis __
DVT ____

NEUROLOGIC Fainting ____ Light Headedness ___ Blackouts ____
Seizures ____ Tremors ___ Numbness ____ Tingling ____ Pins & Needles ____
Memory Problems ____

OVERALL Weakness ____ Fatigue ___ Recent Weight Loss ___ Weight Gain ___
Fever __ Hot/Cold Intolerance ___ Excessive Sweating ___ Easy Bruising ___
Tension __ Nervousness ___ Depression ___ Anxiety ____ Panic Attacks ____

ALLERGIES Hay Fever ____ Food Intolerance ____ Frequent Infections____
Other _____

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Please list all MEDICATION allergies:

___

Medical History:

Illnesses: ___

Hospitalizations: ___

Injuries: ___

Psychiatric Illnesses: Depression ___ Anxiety ___ Panic Attacks ___

Other (please describe): ___

Surgical History:

Surgery: ___ Date: ___

Surgery: ___ Date: ___

Surgery: ___ Date: ___

Surgery: ___ Date: ___

Habits:

1) Alcohol.....Beer amount per week ___ Wine amount per week ___

   Hard liquor amount per week ___

2) Tobacco..... Yes ☐ No ☐

3) Packs per day ___ Years ___

4) Recreational Drugs? Yes ☐ No ☐

   Type ___ Route ___

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Please check all medical conditions or therapies that apply to you:

- ☐ pregnancy / recent childbirth
- ☐ high blood pressure
- ☐ currently smoking
- ☐ migraine headaches
- ☐ chemotherapy
- ☐ metal bone pins or plate
- ☐ panic attacks / anxiety
- ☐ brain or neurological surgery
- ☐ heart condition
- ☐ keloid or unusual scars
- ☐ hysterectomy /oophorectomy
- ☐ excessive bleeding
- ☐ unintentional weight gain
- ☐ hormone imbalance
- ☐ varicose veins
- ☐ facial surgery
- ☐ cosmetic implants
- ☐ thyroid abnormalities
- ☐ hormone replacement therapy
- ☐ permanent cosmetics
- ☐ herpes zoster
- ☐ unwanted hair growth
- ☐ Accutane or gold therapy
- ☐ hot flashes / night sweats
- ☐ psychological counseling
- ☐ unintentional weight loss
- ☐ epilepsy
- ☐ diabetes
- ☐ eczema
- ☐ asthma
- ☐ acne
- ☐ cancer
- ☐ rosacea
- ☐ HIV positive
- ☐ age/sun spots
- ☐ chest pain
- ☐ seborrhea
- ☐ sun tanning
- ☐ depression

Please list any other health concerns or illnesses not listed above: ____________
____

Please list any surgeries or injuries you had in the last 12 months: ____________
____

Please list any medications you currently take, including hormone injections or topical creams you may use ______________________________
____

Please list any food, cosmetic or drug allergies ______________________
____

What would you like us to help you improve today? ____________________

For laser therapies, please provide the following dates:

Last use of Retin A _________ last menstrual period (females only) __________
Last taken Accutane or gold therapy _________ Glycolic treatment __________
Last microdermabrasion ___________ last laser therapy ______________
Last use of bleaching creams, hair removal creams or waxing to the area to be treated today ____________ last sun tan or tanning bed use ____________
Last Botox treatment _________ Last filler injections ______________

Please circle any of the following if you have taken in the last two weeks:
St. John's Wort, Bufferin, Advil, Ibuprofen, Nuprin, vitamin E, fish oil, aspirin

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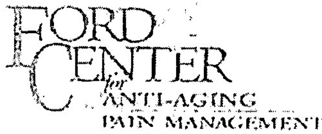

For hormone therapies, please circle any of the following symptoms that you experience: anxiety, fatigue, insomnia, headaches, mood swings, erectile dysfunction, hair loss, organ removal, hot flashes, night sweats, irregular menses, irritability, vaginal dryness, breast tenderness, dry skin or hair, aggressiveness, memory loss, thinning eyebrows, fluid retention, decreased libido, memory loss, weight gain, weight loss

What other hormone therapies have you tried?______________________

____

When did you last have your hormone levels tested? ______________

If you are interested in **weight loss therapy**, please indicate:

Have you ever been diagnosed with diabetes? Yes☐ No☐ If yes, when? _______

Please list any heart conditions you may have ______________________

or please check ☐ I have no known heart conditions

If you have you had any history of cancer, please describe______________

or please check ☐ I have no history of any type of cancer.

What is your desired weight? ________ What is your current weight? _______

Please indicate how you learned of our services.....

☐ yellow pages	☐ newspaper	☐ friend ____________
☐ TV / radio ad	☐ brochure / flyer	☐ website ____________
☐ physician	☐ office poster	☐ other ____________

Authorization

I certify that this information provided is complete and accurate to the best of my knowledge. I understand that payment for all services rendered at Ford Center for Anti-Aging and Pain Management are due at the time that services are provided. My information will remain confidential and will only be discusses with any names I wrote above. I will submit all changes in writing. I authorize Dennis C. Ford, MD and his representatives to provide therapeutic and cosmetic services. I hereby permit Dennis C. Ford, MD or any assistant that he may designate to take photographs for diagnostic and evaluation purposes. I further authorize him to use such photographs for teaching purposes, to illustrate scientific papers, books, lectures, medical research, public education, pamphlets or via website. These photographs will remain the physician's property. I understand that in any such use, I will not be identified by name.

______________________ ______________________

Signature Date