Solimar MediSpa

PATIENT CONTACT INFORMATION

On occasion we will contact you regarding your weight loss program and ongoing promotions.

To better serve you, please provide us with your **e-mail address** and **cell phone number**.

CELL PHONE: ____

E-MAIL: ____

Patient Name (Print): ____

Patient Signature: ____

Date: ____

Witness: ____

PATIENT INFORMATION FORM

Patient Name: ____

(Last) (First) (MI)

Patient Address: ____

City: ___________________________ State: ____________________ Zip: ___________________

Date of Birth: _______________ Age: _____________ Sex: M F

Employment Information:

Patient Employer: ____

Occupation: ____

Employer Address: ____

City: ___________________________ State: ____________________ Zip: ___________________

Work Phone No: ____ Ext: ___________________

How Did You Hear About Us?

☐ Internet ☐ Email ☐ Phone: Other (please specify): _______________________

☐ Doctor Referral (please specify who so we can send a Thank You)

☐ Patient Referral (please specify who so we can send a Thank You)

In Case of Emergency:

Name: ___________________________ Relationship: ________________ Phone: _____________

Patient's Spouse / Partner: ______________________________________ Phone: _____________

Family Physician: ____ Phone: _____________

MEDICAL HISTORY FORM

Name: ____ Date: ____________

Age: ________ Sex: M F

Present Status:

1. Are you in good health at the present time to the best of your knowledge? Yes No
2. Are you under a doctor's care at the present time? Yes No
3. Are you taking any medications at the present time? (If yes, for what): Yes No

What: Dosages:
What: Dosages:
What: Dosages:

4. Any allergies to any medicines? Yes No
5. History of High Blood Pressure? (If yes, at what age): Yes No
6. History of Diabetes? (If yes, at what age): Yes No
7. History of Heart Attack or Chest Pains? Yes No
8. History of Swelling Feet? Yes No
9. History of frequent Headaches/Migraines? Yes No
   Medication for headaches:
10. History of Constipation? Yes No
11. History of Glaucoma? Yes No
12. Gynecological History
    Are you pregnant? Yes No
    Nursing? Yes No
    Pregnancies:
    Number: __________ Dates: __________
    Natural Delivery or C-Section (specify): ________________
    Menstrual:
    Onset: __________ Duration: _________
    Are they regular: Yes No
    Pain associated: Yes No
    Last menstrual period: _________________
    Hormone Replacement Therapy (If yes, which): Yes No
    Birth Control Pills (If yes, which): Yes No

    Last Check Up: ______________________

    PAP: _______________ Mammogram: _______________

13. Serious Injuries? (If yes, specify): Yes No
14. Any Surgery? (If yes, specify which and when): Yes No

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15. Age Health Disease Cause of Death Overweight

Father:
Age ____ Health _____ Overweight? Yes No

Disease ____ Cause of Death __________

Mother:
Age ____ Health _____ Overweight? Yes No

Disease ____ Cause of Death __________

Brothers:
Age ____ Health _____ Overweight? Yes No

Disease ____ Cause of Death __________

Sisters:
Age ____ Health _____ Overweight? Yes No

Disease ____ Cause of Death __________

Has any blood relative ever had any of the following (If yes, specify who):

Glaucoma:	Yes	No
Asthma:	Yes	No
Epilepsy:	Yes	No
High Blood Pressure:	Yes	No
Kidney Disease:		
Diabetes:	Yes	No
Tuberculosis:	Yes	No
Psychiatric Disorder:	Yes	No
Heart Disease/Stroke:	Yes	No
Cancer:	Yes	No

16. Wellness Labs performed within the last 12 months: ____________________________
17. EKG performed within the last 12 months: ____________________________________

Past Medical History: (check all that apply)

___ Heart Disease
___ Diabetes
___ Hepatitis
___ Autoimmune Disease
___ High Blood Pressure
___ Keloids
___ Psoriasis
___ Vitiligo
___ Melasma
___ Photosensitivity
___ Hormone Treatment
___Thyroid Cancer

___ Asthma/Allergies
___ Liver Disease
___ Sensitive Skin
___ Neuro-Muscular Disorder
___ Cold Sores/Fever Blisters
___ Wear Contacts
___ Muscle Weakness
___ Bleeding Disorders
___ Cancer
___ Epilepsy
___ Skin Cancer

Do you smoke? ______ How often? ______
Do you drink? ______ How often? ______

Previous Cosmetic Procedures:
Have you had any previous Aesthetic or Laser Treatments? If so, please list with dates:

____

____

Previous Dermal Fillers _____________ Date _______________
Previous Botox ____________________ Date _______________

18. What do you think your skin type is? (Circle one)

Dry Oily Sensitive Combination

19. What is your biggest concern? (Circle all that apply)

Lines/Wrinkles
Deep Lines
Volume Loss
Rough Texture
Redness
Acne
Unwanted Hair
Cellulite
Excessive Weight Gain
Sun Spots

Nutrition Evaluation:

1. Present Weight: _______________
   Height (no shoes): _____________
   Desired Weight: _______________

2. In what time frame would you like to be at your desired weight? ____________________

3. Birth Weight: _________________
   Weight at 20 years of age: ________________
   Weight one year ago: ____________________

4. What is the main reason for your decision to lose weight?
   ____

5. When did you begin gaining excess weight? (Give reasons, if known):
   ____

6. What has been your maximum lifetime weight (non-pregnant) and when?
   ____

7. Previous diets you have followed (Give dates and results of your weight loss):
   ____

8. Is your spouse, fiancée or partner overweight? Yes No

9. By how much are they overweight? ____

10. How often do you eat out? ____

11. What restaurants do you frequent? ____

12. How often do you eat "fast foods?" ____

13. Who plans meals? _______________ Cooks? _______________ Shops? ________________

14. Do you use a shopping list? Yes No

15. At what time of day do you do groceries? ____

16. Food Allergies: ____

17. Food dislikes: ____

18. Food you crave: ____

19. Any specific time of day you crave food? ______________________________________

20. Do you drink coffee or tea? Yes No How much daily? ___________

21. Do you drink cola drinks? Yes No How much daily? ___________

22. Do you drink alcohol? Yes No How often? _______________

23. Do you use a sugar substitute? __________ Butter? __________ Margarine? _________

24. Do you awaken hungry during the night? Yes No

25. What are your worst food habits? ____

26. Snack habits: What? _____________ How Much _____________ When? ____________

27. When you are under a stressful situation, do you tend to eat more? Explain:

____

28. Do you think you are currently undergoing a stressful situation? Explain:

____

29. Smoking habits (**Answer only one**):

You have never smoked cigarettes, cigars, or a pipe.
You quit smoking years ago and have not since.
You have quit smoking cigarettes and now smoke cigars or a pipe without inhaling.
You smoke a pack per day
You smoke two packs per day

30. Typical Breakfast: ________________________________ Time eaten: _______________
Typical Lunch: __________________________________ Time eaten: _______________
Typical Dinner: _________________________________ Time eaten: _______________

31. Describe your typical energy level: ____

32. Activity Level (Circle one): Inactive Light Moderate Heavy

33. Please describe your general health goals and improvements you wish to make:

____

____

Solimar MediSpa

I understand that the information on this form is essential to determine my medical and cosmetic needs and the provision of treatment. I understand that if any changes occur in my medical history/health I will report it to the office as soon as possible. I have read and understood the above medical questionnaire. I acknowledge that all answers have been recorded truthfully and will not hold any staff member responsible for any errors or omissions that I have made in the completion of this form.

Patient Signature: ______________________________________ Date: _________________