Patient Information

Name:_________________________________ Date:__________ Date of Birth:_________ Age:_____

Weight:________ Sex: ☐ M ☐ F Occupation:____

Home Address:____

Home Phone:_________________ Cell Phone:__________________ Work Phone:________________

Preferred Contact #:_______________ Email Address:_______________________________________

In Case of Emergency Contact:_______________________________ Relationship:________________

Home Phone:_________________ Cell Phone:__________________ Work Phone:________________

Primary Care Physician:__________________________________ Phone #:______________________

Address:____

Medical History

Last Check Up With PCP:____________________ Current Medications (Please list dosage and frequency):

____

____

Drug Allergies:____

____

Food Allergies:____

____

Surgical History (If so, please list dates):____

____

Have you ever had any issues with local anesthesia? ☐ Y ☐ N Do you have a latex allergy? ☐ Yes ☐ N

☐ I smoke cigarettes or cigars _________ per day. ☐ I use e-cigarettes _________ a day.

☐ I use caffeine _________ a day. ☐ I drink alcoholic beverages _________ per week.

Medical History (Continued)

- ☐ Heart disease
- ☐ Stroke and/or heart attack
- ☐ Atrial fibrillation or other arrhythmia
- ☐ High blood pressure or hypertension
- ☐ Diabetes
- ☐ Blood clot and/or pulmonary embolism
- ☐ HIV or any type of hepatitis
- ☐ Lupus or other autoimmune disease
- ☐ Thyroid disease
- ☐ Liver disease
- ☐ Bleeding disorders
- ☐ Cancer
- ☐ Sleep Apnea
- ☐ Asthma/Allergies
- ☐ Arthritis
- ☐ Photosensitivity
- ☐ Sensitive Skin
- ☐ High cholesterol
- ☐ Epilepsy
- ☐ Keloids
- ☐ Psoriasis
- ☐ Neuro-muscular disorder
- ☐ Muscle weakness
- ☐ Depression/anxiety
- ☐ Psychiatric disorder
- ☐ Cold sores/ fever blisters
- ☐ Other

Family History

☐ Heart disease ☐ Diabetes ☐ Osteoporosis ☐ Alzheimer’s/dementia ☐ Breast cancer ☐ Other

Weight Loss and Wellness

Previous diets you have followed: (Please list dates and results of your weight loss)

____

____

How often do you eat out?____

What restaurants do you frequent?____

How often do you eat “fast foods”?____

Foods you crave:____

Any specific time of day you crave food?____

Do you drink soda?_________________________ How much daily? _________________________

Do you awaken hungry during the night? ☐ Y ☐ N

Weight Loss and Wellness (Continued)

What are your worst food habits?____

____

Snack habits:

What?____

How much?____________________________________ When? ______________________________________

Describe your typical energy level:____

Activity level (Circle one): Inactive Light Moderate Heavy

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

____

____

____

Wellness labs performed within the last 6 months:____

EKG performed within the last 6 months:____

MediSpa

Have you had any previous aesthetic or laser treatments? (If so, please list dates)

____

____

Previous Dermal Fillers:_________________________________ Date:______________________

Previous Botox:____________________________________ Date:________________________

Hormone Replacement Therapy

Current hormone replacement? ☐ Y ☐ N If yes, list type and dosage:_______________________________

Past hormone replacement therapy:____

Social:

☐ I am sexually active. ☐ I want to be sexually active. ☐ I do not want to be sexually active.

☐ I have completed my family. ☐ I have not completed my family.

☐ My sex life has suffered. ☐ I have not been able to have an orgasm or it is very difficult.

<u>**Hormone Replacement Therapy (Continued)**</u>

Activity Level:

- ☐ Low – sedentary
- ☐ Moderate – walk/jog/workout infrequently
- ☐ Average – walk/jog/ workout 1 to 3 times per week
- ☐ High – walk/job/workout regularly 4+ times per week

Female Pertinent Medical/Surgical History:

- ☐ Breast cancer
- ☐ Uterine cancer
- ☐ Ovarian cancer
- ☐ Polycystic ovaries/PCOS
- ☐ Acne
- ☐ Excess facial/body hair
- ☐ Thinning/hair loss
- ☐ Infertility
- ☐ Epilepsy or seizures
- ☐ Fibrocystic breast or breast pain
- ☐ Uterine Fibroids
- ☐ Irregular or heavy periods
- ☐ Menstrual migraines
- ☐ Hysterectomy (with removal of ovaries)
- ☐ Hysterectomy (uterus only)
- ☐ Oophorectomy (removal of ovaries only)
- ☐ Endometriosis

Birth Control Method:

- ☐ Not Applicable
- ☐ Menopause
- ☐ Hysterectomy
- ☐ Tubal ligation
- ☐ Birth control pills
- ☐ Vasectomy
- ☐ IUD
- ☐ Infertility
- ☐ Other________________

Last Pap:________________________ Last Mammogram:_________________________

Male Pertinent Medical/Surgical History

- ☐ Cancer (type):
  Year:_______________
- ☐ Elevated PSA
- ☐ Trouble passing urine
- ☐ Frequent blood donations
- ☐ Taking medicine for prostate or male pattern balding
- ☐ History of anemia
- ☐ Taking medicine for high cholesterol
- ☐ Testicular or prostate cancer
- ☐ Prostate enlargement or BPH
- ☐ Kidney disease or decreased kidney function
- ☐ Vasectomy
- ☐ Non-cancerous testicular or prostate surgery
- ☐ Severe snoring
- ☐ Erectile disfunction

Birth Control Method:

- ☐ Not Applicable
- ☐ Vasectomy
- ☐ Depend on partner's contraception
- ☐ None – planning pregnancy in the next year
- ☐ Condoms
- ☐ Other:____________