

PATIENT REGISTRATION & HEALTH QUESTIONNAIRE

PATIENT INFORMATION

Name: _____ Date of Birth: _____
 First Middle (Maiden) Last

Male Female

Social Security Number: _____ - _____ - _____

Single Married Other: _____

Driver's License: _____
 Number State

Legal Guardian or responsible party (if different from above): _____

Home Address: _____

Street

City State Zip

Billing Address: _____ Occupation: _____

(If different from above) Street

City State Zip

Employer: _____

Email Address: _____ Would you like to receive our educational monthly newsletter? Yes No

Home Phone: () _____ Mobile: () _____ Office: () _____

Please mark (check box) which of the above numbers is the most convenient to reach you or leave messages.

Emergency Contact: _____

Name

Telephone

Relationship

REFERRAL INFORMATION

How did you hear about our office?

Referred by another physician _____
 Name Telephone

Referred by another patient _____
 Name

Referred by affiliated industry (facialist/hair salon, etc.): _____

Website: _____ Yellow Pages: _____
 Website Address Book/Area (ex: GTE/Santa Monica)

Insurance Directory (which company?): _____ Other: _____

PATIENT REGISTRATION & HEALTH QUESTIONNAIRE

MEDICAL HISTORY

Do you have any history of:

- | | | | | | | | | |
|-------------------------------------|------------------------------------|--|-------------------------------------|------------------------------------|--|-------------------------------------|------------------------------------|--|
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Artificial Joints | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Family of Bleeding Problems | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Heart Disease |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> Liver Disease/Hepatitis | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> Bleeding Problems | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> Artificial Heart Valve | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> Keloids |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> Difficulty Healing Wounds | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> Pacemaker: _____ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> Kidney Disease |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> Emotional Disorders | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> Blood Clots |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> Fever Blisters | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> Diabetes | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> Glaucoma |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> Thyroid Problems | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> Cancer: (type) _____ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> Taken Medicine Accutane |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> Immune Deficiency/HIV | | | | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | Require Antibiotics before medical/dental Procedures? If yes, why? _____ | | | | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | Any complications with previous surgeries? _____ | | | | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | Prior Cosmetic Procedures: _____ | | | | | | |

Additional information for "yes" answers: _____

CURRENT MEDICATION/DRUG ALLERIGES: include dietary supplements, aspirin, and birth control pills

Current Medication/Dosage

1. _____
2. _____
3. _____
4. _____
5. _____

Drug Allergies

1. _____
2. _____
3. _____
4. _____
5. _____

DERMATOLOGIC HISTORY

1. Is there a history of melanoma in your immediate family? Yes No If yes, who? _____
2. Do you have a history of severe sunburn(s) as a child or a teen? Yes No
3. Do you regularly sunbathe or visit tanning salons? Yes No
4. Do you regularly apply sunblock to exposed areas? Yes No If yes, which brand/SPF? _____
5. Do you or anyone in your family have a history of any skin disease? (rashes, eczema, psoriasis, etc.) Yes No If yes, please explain _____
6. What is your current skin care regimen? (brand and products) _____

TODAY'S VISIT (please not that multiple problems may require more than one visit)

1. What is the primary reason for your visit today? (Check all that apply)

<input type="checkbox"/> Acne	<input type="checkbox"/> Rash	<input type="checkbox"/> Hair loss	<input type="checkbox"/> Cosmetic (Hair Transplant/Collagen/Botox/Laser Procedures, etc.)
<input type="checkbox"/> Changing Mole/Skin Growth	<input type="checkbox"/> Full Body Check/Skin Cancer Screening	<input type="checkbox"/> Other _____	
2. Are you interested in learning more about any of the following procedure we also offer? (Check all that apply)

<input type="checkbox"/> Dermal Fillers Restylane/Juvederm	<input type="checkbox"/> Botox	<input type="checkbox"/> Latisse Eyelash Solution
<input type="checkbox"/> Sclerotherapy (leg veins)	<input type="checkbox"/> Hair Loss	<input type="checkbox"/> Chemical Peels
<input type="checkbox"/> Fraxel Laser Resurfacing	<input type="checkbox"/> Laser Tattoo Removal	<input type="checkbox"/> Photofacial/IPL
<input type="checkbox"/> Skin Cancer Surgery	<input type="checkbox"/> Other _____	<input type="checkbox"/> Skin Care
		<input type="checkbox"/> Other Laser Treatments

Patient Signature

Date