Patient Health Information

Date_____ Social Security #_____

Patient Name Last_____ First_____MI_____

Birth date_____/_____/_____ Age____ Race_____ Sex_____

Address_____ Home Phone( )_____

City_____State_____Zip Code_____

E-mail Address_____

Employer_____ Work #( )_____

Primary Care Physician_____

Were you referred to us by a friend or family? If so, by who._____

Allergies: No_____ Yes_____ **Please indicate any reactions to medications, drugs, suture, tape, rubber, and the type of reaction** (ie. Hives, shock, breathing disorders)_____

_____

Do you have a history of Herpes Infection on the face or mouth? Yes_____or No_____

Have you been tested for HIV (AIDS)? No_____ Yes_____ Positive Negative

Have you ever had Hepatitis? No_____ Yes_____ If yes, specify type and date_____

Have you ever take Accutane? No_____ Yes_____ If yes, when? _____

Do you smoke? No_____ Yes_____

What is your skin type? (Please circle one)
Dry/normal Combination Oily

Is there anything you would change about your skin?_____

_____

CURRENT MEDICATIONS: **Please list all medications you are now taking and their dosages** (including birth control pills, diuretics, blood pressure or heart medications, tranquilizers, hormones, blood thinners, aspirin, etc.) _____

_____

MEDICAL HISTORY

Do you have any illnesses, injuries or disorders of the following? Circle all that apply.

Brain(including strokes, epilepsy) Face(paralysis) Lungs(including asthma) Intestines Blood

Bones/joints Eyes(including glaucoma, dryness) Nose, sinus, throat Heart or blood vessels

Liver Reproductive system Arms/ Legs Ears Breasts Stomach Urinary System

Nervous System Endocrine or Diabetes Fatigue Recent Weight Change

Unusual Reaction to Sun Hair Loss

If circled, please explain:_____

_____

Also include any previous leg vein work you might have had done.(e.g. schlerotherapy, endovascular procedure, or stripping.

Signature_____

_____ _____

Name (if form completed by someone other than patient) relationship