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PATIENT INFORMATION FORM **PLEASE PRINT INFO ON THIS FORM
FOR SURGERY, WEIGHT LOSS AND SKIN CARE PATIENTS**

Today's Date _____
Patient Last Name _____ Patient First Name _____
Middle Initial _____

Date of Birth _____ Age _____ Cell Phone _____
Work Phone _____ Home Phone _____
Home Address _____ City _____ State _____ Zip _____

E-mail Address _____

Height _____ Weight _____

Marital Status: Single Divorced Married Other _____

Your Profession/Occupation _____

Employer's Name and Location _____

Spouses Name _____ Spouses Employer _____

Spouses Profession/Occupation: _____

Do you have children? _____ If so, how many? _____ Age of youngest child? _____

Are you pregnant or planning to get pregnant? _____

Do you smoke? _____ How many packs per day? _____

Do you exercise? _____ How often? _____

What type of exercise? _____

When was your last physical? _____

Physician's Full Name _____

Address _____

Past illnesses _____

Past surgeries _____

Allergic to any medications: YES NO

If allergic, what medications? _____

What regular medications do you take? Please List.

Name of med.	Dosage	How often	Reason
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_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

What supplements/vitamins do you take? Please list.

Name Dosage How often Reason

Do you have asthma or respiratory problems? Explain if yes:

Do you take medication to control blood pressure? _____

Name, Dosage of BP Meds _____

Reason for visit: _____

Describe previous methods utilized to lose weight:

How were you referred to this office? _____

FEES ARE PAYABLE AT THE TIME OF SERVICE.

What procedure are you interested in?

- | | |
|---|-----------------------------------|
| Weight Loss Program | Facial Resurfacing |
| Hormone Replacement | Wellness Consultation/Supplements |
| Skin Care | Breast Augmentation |
| Microdermabrasion | Breast Reduction |
| Microdermabrasion with Chemical Peel | Rhinoplasty |
| Non-Surgical Thinning Hair Treatment | Liposuction/lipo-dissolve |
| Non-Surgical Body Contouring (Synergie) | Botox |
| Juvederm, Sculptra Fillers | Tummy Tuck |

Past Medical History (Please indicate any illnesses that you have been treated for: items not indicated are understood to be negative.)

- | | | | | |
|-----------------------------|--------------|---------------|------------------|---------------|
| Abnormal Bleeding | Pneumonia | Cancer | Diabetes | Heart Disease |
| High Blood Pressure | Ulcer | Hepatitis | Kidney Disease | Anemia |
| AIDS/HIV Positive | Arthritis | Liver Disease | Asthma | Gout |
| Peripheral Vascular Disease | Anxiety | Emphysema | Phlebitis | Stroke |
| Rheumatic Fever | Tuberculosis | Blood Clot | Epilepsy/Seizure | |
| Previous Back/Neck Injury | Polio | Osteoporosis | Thyroid Disorder | |

Other: _____ None

(Please indicate any conditions your family members have: items not circled are understood to be negative.)

- | | | | | |
|------------------------|----------------------|----------------|--------------|--------------|
| Abnormal Bleeding | Rheumatoid Arthritis | Bleeding Ulcer | Osteoporosis | Cancer |
| Ankylosing Spondylitis | Bone Disease | Lupus | Gout | Hypertension |
| Heart Disease | Ulcerative Colitis | Crohns Disease | Stroke | Diabetes |

Is there any other information you would like us to be aware of?

I verify that the above information is an accurate representation of my past and current health.

Signature of patient _____ Date: _____

Please print your name. _____