ADVANCED AESTHETICS

## PERSONAL INFORMATION:

**PATIENT NAME:** _____

**REASON FOR VISIT:** _____

**DATE OF BIRTH:** _____ **HEIGHT:** _____ **WEIGHT:** _____

**EMERGENCY CONTACT NAME & PHONE NUMBER:** _____

**PRIMARY CARE PHYSICIAN NAME & LOCATION:** _____

**OCCUPATION:** _____

**BEST NUMBER TO REACH YOU:** _____ ☐ Home ☐ Cell ☐ Work
Is it okay to leave confidential messages at this number? ☐ Yes ☐ No

**EMAIL ADDRESS:** _____
Is it okay to email you appointment reminders? ☐ Yes ☐ No

Would you like to receive promotional offers via email (i.e., specials, events, etc.)? ☐ Yes ☐ No

**HOW DID YOU HEAR ABOUT US?** (Check all that apply):

☐ Google
☐ Yelp
☐ Facebook
☐ Instagram
☐ Referred By Patient: _____
☐ Referred By Doctor: _____
☐ Other: _____

## MEDICAL INFORMATION:

**PAST MEDICAL HISTORY** (cancer, diabetes, etc.): _____

**PAST SURGICAL HISTORY** (plastic surgery, knee surgery, etc.): _____

**CURRENT MEDICATIONS:** _____

**DRUG ALLERGIES:** _____

**FAMILY MEDICAL HISTORY** (cancer, heart attack, etc.): _____

**ARE YOU CURRENTLY TAKING ANY BLOOD THINNING MEDICATIONS?** (i.e., Aspirin, Plavix, Coumadin®, XARELTO®, Advil, ELIQUIS®, MOTRIN®, Aleve®) ☐ Yes ☐ No If yes, please list: _____

**DO YOU CURRENTLY USE ANY OF THE FOLLOWING? IF SO, HOW MANY TIMES PER WEEK?**
Tobacco: ☐ Yes ☐ No _____ Alcohol: ☐ Yes ☐ No _____ Recreational Drugs: ☐ Yes ☐ No _____

**DO YOU HAVE A HISTORY OF ANY OF THE FOLLOWING?** (Check all that apply):

☐ Previous Skin Cancer: Where? _____
☐ Cold Sores/Herpes
☐ Heart Disease
☐ Lung Disease
☐ Chest Pain
☐ Shortness of Breath with Stairs
☐ Diabetes
☐ Easy Bleeding
☐ Hepatitis A/B/C
☐ HIV
☐ Abnormal Healing/Scaring
☐ Stomach Ulcer/Bleeding
☐ Seizure/Strokes
☐ Depression/Other Psych

**Is there anything else you would like us to know?** _____

_____

Signature: _____ Date: _____