Date:______________

FEMALE COSMETIC PATIENT INFORMATION

Name:____ **Date of Birth:**____________

Last First Middle

Address:____

City:______________________________ **State:**________ **Zip Code:**______________

Phone Numbers: Home:______________________ **Cell:**________________________

E-mail Address (for office use only will not be shared):___________________________________

How did you hear about Us? ____

Patient employed by:____

Occupation:____

Business Address:____

Business Phone:____

Social Security # :___________________________

In case of emergency, whom should we notify:___________________________________

Emergency Phone Numbers:____

Sex: Male _________ Female _________ Transgender _________

Marital Status: Married ______ Divorced________ Single ________

Widow _______ Living with significant other _______

Is it ok to leave a message with lab work results on your voice-mail: (please circle) Yes No

What phone number would you like us to call with lab results and/or appointment reminders?

Phone #: ____________________________________

*****Payment is due at time of service.*****

Payment types accepted: Cash, Check, or Money Orders, Care Credit, or Prosper Healthcare

Patient Name:____ **DOB:**________________

Height ________________ **Weight** __________________

Habits: Alcohol: Y N Daily Exercise: Y N

Smoke: Y: Currently, ________ packs per day Socially _________

N: I quit _______ years ago I do not smoke __________

Medications: List dose or number of pills per day.

____

____

____

____

____

Supplements (OTC, Vitamins, Herbs): List dose or number of pills per day

____

____

Regular Aspirin use: Y N Dosage & frequency:__________________

NSAIDS (Advil, Motrin, Ibuprofen, Naproxen, Aleve) Y N Dosage & frequency:__________________

Latex Allergy: Y N

Tape/Adhesive Allergy: Y N

Egg Allergy: Y N

Drug Allergy Y N

If yes, list drug(s) and type of reaction:____

Family History: Have any blood relatives (mother, father, brothers, sisters) ever had the following? **Please DESCRIBE any "YES" answers:**

Abnormal Bleeding: Y N ____

Coronary Surgery: Y N ____

Kidney Disease: Y N ____

Abnormal Clotting: Y N ____

Diabetes: Y N ____

Tuberculosis: Y N ____

Asthma: Y N ____

Heart Attack: Y N ____

Cancer: Y N ____

Hypertension: Y N ____

Other serious illnesses: Y N ____

Medical History: Circle all that apply.

Lungs: **No problems** Bronchitis Asthma Shortness of Breath Cough Wheezing Emphysema Tuberculosis

Cardiovascular: **No problems** Blood Clot Hypertension Heart Attack Pacemaker Leg Swelling/Leg Ulcers Murmur Anemia Irregular Heartbeat Mitral Valve Prolapse

Gastrointestinal: **No problems** Bleeding Stools Vomiting Reflux Ulcers Nausea

Endocrine/ID: **No problems** Thyroid disorder Diabetes Pituitary Disorder Growth Hormone Disorder Blood Transfusion (Date:__________) Adrenal HIV Hepatitis: A B C

ENT: **No problems** Ear Infections Nasal Polyps Sinus Problems Tumor Oral Ulcerations Dentures Sleep Apnea

Oncology: **No problems** History of Cancer (Type):______________________________

Rheumatology: **No problems** Lupus Arthritis Scleroderma Limited Motion

Ophthalmology: **No problems** Cataracts Contacts Glasses Eye Allergies Dry Eyes Glaucoma Lasik Surgery Double Vision

Neurologic: **No problems** Seizures Numbness Nerve Palsy Migraines Fainting Stroke Psychological (Type):____

Musculoskeletal: **No problems** Bone Fracture(s) Hip/Shoulder/Knee Replaced Back Injury Neck Injury

Skin: **No problems** ______

History of Skin Cancer? Y N

Melanoma Basal Cell Squamous Cell Cancer

Do you heal poorly? (keloids/hypertrophic scarring?) Y N

Do you bruise easily? Y N

Do you sunburn easily? Y N

Do you develop rashes from the sun? Y N

Have you ever had cold sores, fever blisters, shingles? Y N

Do you suffer from eczema or psoriasis? Y N

Do you have any type of skin disorders? Y N

Please describe:________________________________

Do you have varicose veins? Y N

Do you require antibiotics before surgery? Y N

Past Surgeries & Procedures:

Type & Year

____

____

____

Complications/reactions to anesthesia you experienced:

Local anesthesia:____

General anesthesia:____

FEMALE PATIENTS ONLY:

Last Menstrual Period:______/______/______

Do you think you are pregnant? Y N

Have you had a Hysterectomy? Y N

Are you taking any hormonal therapies? Y N

Are you post-menopausal? Y N

Notes:

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Hebron Office ▪ 2940 Hebron Park Dr., Ste. 301, Hebron, KY 41048 ▪ 859-429-3333 ▪ Fax 859-869-0248

Montgomery Office ▪ 9509 Montgomery Rd., Cincinnati, OH 45242 ▪ 513-401-6030 ▪ Fax 859-869-0248