

NEW/UPDATED PATIENT INFORMATION



NAME _____ SS# _____
ADDRESS _____
CITY/STATE _____ ZIP _____
HOME PHONE _____ CELL PHONE _____
WORK PHONE _____ EMAIL _____
EMPLOYER _____ OCCUPATION _____
BIRTH DATE _____ single married widow(er) GENDER: male female
SPOUSE'S NAME _____ SPOUSE'S EMPLOYER _____
REFERRAL SOURCE _____
PHARMACY _____ PHARMACY PHONE _____

MINOR OR STUDENT INFORMATION

MOTHER'S NAME _____ BIRTH DATE _____ PHONE _____
ADDRESS _____
CITY/STATE _____ ZIP _____
FATHER'S NAME _____ BIRTH DATE _____ PHONE _____
ADDRESS _____
CITY/STATE _____ ZIP _____

EMERGENCY CONTACT

NAME _____ RELATIONSHIP TO PATIENT _____
HOME PHONE _____ WORK PHONE _____

SURGICAL HISTORY LIST ANY PROCEDURES YOU HAVE HAD AND APPROXIMATE DATES

MEDICATION ALLERGIES LIST ANY MEDICATION ALLERGIES OR OTHER ALLERGIES

MEDICATIONS LIST ANY MEDICATIONS TAKEN ROUTINELY

Occasionally, our staff may contact you to remind you of upcoming appointments or check on your progress. Please see below.

- I give Southern Face & Body permission to call or leave messages for me at the above listed phone numbers.
 I do not give Southern Face & Body permission to call me.
 I give Southern Face & Body permission to email me promotional materials.
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CONSULTATION & MEDICAL HISTORY

NAME _____ AGE _____
 OCCUPATION _____ DATE _____

What area(s) of the face are you interested in having improved? _____

What services are you interested in?

- Injections Laser (hair, veins, pigmentation) Skincare Cellulite
 Surgery BodySculpting Skincare products

How is your general health? _____

ARE YOU PRESENTLY BEING TREATED FOR ANY MEDICAL CONDITIONS?

EYE

- Visual loss (one or both eyes) yes no
 Dry Eyes yes no
 Itching or irritation of eyes yes no
 Blurred or double vision yes no
 Crossed or lazy eyes yes no
 Cornea problems yes no
 Thyroid eye disease yes no
 Wear glasses or contacts yes no
 Previous eye or eyelid surgery yes no

CARDIOVASCULAR

- Hypertension yes no
 Coronary or heart attack yes no
 Congenital heart disease yes no
 Heart murmur yes no
 Stroke yes no

PSYCHIATRIC

- Previous drug/alcohol dependency yes no
 Previous psychiatric treatment yes no

ALLERGIES

- Latex allergy yes no
 Tape allergy yes no
 Drug allergies yes no

If yes, list drug & reaction type:

MEDICATIONS

- Are you currently on aspirin? yes no

List current medications & dosage within the last month (including vitamin & herbals): _____

SIGNATURE: _____

NOSE

- Difficulty breath through nose yes no
 Previous injury to nose yes no
 Nose bleeds yes no
 Nasal allergies yes no
 Previous nasal or sinus surgery yes no
 Previous face or neck surgery yes no
 Irradiation of face or neck yes no
 Facial paralysis or weakness yes no
 Facial skin problems yes no

CHEST

- Shortness of breath yes no
 Chronic lung disease yes no
 Chronic cough yes no
 Asthma yes no
 Do you smoke yes no

OTHER

- Liver disorder yes no
 Kidney or bladder disorders yes no
 Spinal or back disorders yes no
 History of blood clots yes no
 Bleeding disorders yes no
 Blood transfusion yes no
 Autoimmune disease yes no
 Unusual scarring/keloid formation yes no
 If applicable, are you pregnant yes no
 Date of last menstrual period _____
 Diabetes yes no
 History of seizures yes no
 History of fever blisters yes no

SOCIAL

- Drink more than 2 drinks a day yes no