



Name: \_\_\_\_\_ Date: \_\_\_\_\_  
(Last) (First) (Middle)

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Social Security Number: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_

Work Phone: \_\_\_\_\_

E-mail: \_\_\_\_\_

What is the best way to reach you? \_\_\_\_\_

Who referred you to this office? \_\_\_\_\_  
MAY WE THANK THEM? \_\_\_\_\_

Reason for Consultation: \_\_\_\_\_

Insurance Provider: \_\_\_\_\_

Policy #: \_\_\_\_\_

Name of your personal Physician: \_\_\_\_\_

Phone: \_\_\_\_\_

Dermatologist: \_\_\_\_\_

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_

Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

Have you ever had? (Please circle yes or no)

Tuberculosis	Yes	No	Kidney Disease	Yes	No
Cancer	Yes	No	Hepatitis	Yes	No
Heart Disease	Yes	No	Diabetes	Yes	No
Lung Disease	Yes	No	Epilepsy	Yes	No

Do you have high blood pressure? \_\_\_\_\_ Treatment: \_\_\_\_\_

Do you have heart trouble? \_\_\_\_\_ Treatment: \_\_\_\_\_

List previous surgeries:

\_\_\_\_\_ Date: \_\_\_\_\_

\_\_\_\_\_ Date: \_\_\_\_\_

\_\_\_\_\_ Date: \_\_\_\_\_

Have you ever had any difficulties with Anesthesia? \_\_\_\_\_

Do you smoke? \_\_\_\_\_ If so, how much per week? \_\_\_\_\_

List any drug allergies: \_\_\_\_\_

Do you take aspirin regularly? \_\_\_\_\_

List current medications:

\_\_\_\_\_ Dosage: \_\_\_\_\_

\_\_\_\_\_ Dosage: \_\_\_\_\_

\_\_\_\_\_ Dosage: \_\_\_\_\_

\_\_\_\_\_ Dosage: \_\_\_\_\_

\_\_\_\_\_ Dosage: \_\_\_\_\_

Are you taking anti-depressants? \_\_\_\_\_ Have you taken any in the past? \_\_\_\_\_

Date \_\_\_\_\_ Dosage \_\_\_\_\_

Have you been tested for HIV? \_\_\_\_\_ Were you Positive or Negative: \_\_\_\_\_

Have you ever had excessive bleeding, i.e. nosebleeds, etc.? \_\_\_\_\_