Patient Information

Name: ____ Date: ___________
Last First MI

Date of Birth: _______________

Street Address: ____

City: ___________________________ State: ________________ Zip Code: _________

Home Phone: ______________Cell Phone: ______________Work Phone: ______________

E-mail: ____

In the event we are unable to contact you by the means you've provided above, please provide your significant other's contact information.

Significant Other: _______________________________

Home Phone: ___________________________ Cell Phone: ________________________

In case of an emergency, whom should we notify if different from above?

Contact Name: _______________________________ Relationship: ________________

Contact Information: ________________________ ___________________________
Home Phone Cell Phone

Do you have a Primary Care Provider? ☐ Yes ☐ No

If yes, may we share your information with your provider? ☐ Yes ☐ No

Provider Name: ________________________ Phone Number: _____________________

How did you hear about us? ____

What services are you interested in discussing (Mark all that apply)?

- ☐ Hormone Replacement Therapy
- ☐ Anti-aging
- ☐ Acne or Rosacea
- ☐ Facials / Peels
- ☐ RF Microneedling
- ☐ Hair removal
- ☐ Skin care advice / Products
- ☐ Sun damage / skin spot removal
- ☐ Nutritional supplements
- ☐ Concierge health plans
- ☐ Weight Management
- ☐ Fine Lines / Wrinkles
- ☐ Botox, Fillers, PDO Threads
- ☐ Specialty facials: Oxygen and PRP
- ☐ Microdermabrasion
- ☐ Hair restoration with PRP
- ☐ Facial / Leg vein treatments
- ☐ Nutragenomic (Genetic) Testing
- ☐ Pharmacogenetic testing (Medications)
- ☐ Other______________________________

Signature: __________________________________ Date: ________________

Print Name: __________________________________

Medical History

Ear, Eyes, Mouth:

Do you have **glaucoma**? ☐ Yes ☐ No

Do you have **tinnitus**/ringing in the ears? ☐ Yes ☐ No

Do you get **cold sores** or **mouth ulcers**? ☐ Yes ☐ No

Have you ever had any type of **mouth, throat, esophageal cancer**? ☐ Yes ☐ No

Neurological:

Do you get **migraine** headaches? ☐ Yes ☐ No

Have you ever suffered a **concussion** or **traumatic brain injury**? ☐ Yes ☐ No

Do you suffer from frequent **vertigo**/dizziness? ☐ Yes ☐ No

Do you suffer from **tremors**? ☐ Yes ☐ No

Endocrinology:

Do you have **thyroid** problems? ☐ Yes ☐ No

If yes, ☐ Hypothyroidism ☐ Hyperthyroidism ☐ Goiter

Do you have **Prediabetes**, Type 1 or 2 **Diabetes** or insulin resistance? ☐ Yes ☐ No

If yes, what type ____________________________

Have you ever had previous **hormone replacement therapy**?

☐ No treatment ☐ Cream ☐ Gel ☐ Patch ☐ Pills ☐ Dissolvable tablet ☐ Shots ☐ Pellets ☐ Other____________________ Last treatment: ________________________

Breasts:

Have you ever had **breast cancer**? ☐ Yes ☐ No

If yes, what type of treatment did you receive?

☐ Lumpectomy ☐ Mastectomy ☐ Radiation therapy ☐ Chemotherapy

Have you ever had or are currently experiencing **nipple discharge** (not associated with lactation or breast feeding)? ☐ Yes ☐ No

Males only: Have you had or currently experiencing **gynecomastia** (enlarged breast tissue)? ☐ Yes ☐ No

Respiratory:

Have you had or are currently experiencing any of the following:

☐ Asthma ☐ COPD ☐ Emphysema ☐ Chronic bronchitis ☐ Pneumonia

Have you ever had **lung cancer?** ☐ Yes ☐ No

If yes, what type of treatment did you receive? ___________________________________

Are you currently on **oxygen** use? ☐ Yes ☐ No

Have you ever had **anesthesia complications**? ☐ Yes ☐ No

If yes, what were your complications? ____

Cardiovascular:

Have you had or are currently experiencing any of the following?

☐ Hypertension	☐ Heart disease	☐ Heart murmur
☐ Atrial fibrillation	☐ Irregular heart rhythm	☐ Varicose veins
☐ Heart valve problems	☐ Heart attack	☐ Rheumatic fever
☐ Stroke	☐ Transient Ischemic Attack (TIA)	

Do you have elevated or abnormal **cholesterol** or **triglyceride** levels? ☐ Yes ☐ No

Do you experience water retention or **edema**? ☐ Yes ☐ No

Gastrointestinal:

Do you experience frequent **bloating**? ☐ Yes ☐ No

Do you have **irritable bowel syndrome** (IBS)? ☐ Yes ☐ No

Have you ever been diagnosed with **celiac disease**? ☐ Yes ☐ No

Have you ever been diagnosed with **ulcerative colitis** or **Crohn's disease**? ☐ Yes ☐ No

Have you ever had **liver disease**? ☐ Yes ☐ No

Have you ever had a **stomach ulcer**? ☐ Yes ☐ No

Have you had **colon polyps**? ☐ Yes ☐ No

If yes, were they cancerous? ☐ Yes ☐ No

Have you had any form of **stomach** or **colon cancer** (stomach, colon, rectal, anal)?

☐ Yes ☐ No

If yes, what type of treatment did you receive? ____________________________________

Genitourinary:

Do you get frequent **urinary tract infections** (approx. 2-3 times a year)? ☐ Yes ☐ No

Do you have issues with **urinary incontinence** (leaking urine)? ☐ Yes ☐ No

Have you ever had **hematuria** (blood in urine not associated with menstrual cycle)?

☐ Yes ☐ No

Do you have a history of **kidney stones**? ☐ Yes ☐ No

Do you have any form of **kidney disease**? ☐ Yes ☐ No

If yes, have you been treated by a nephrologist (kidney specialist)?

Name: ____

Are you **sexually active**?

☐ No, not sexually active ☐ Yes, opposite sex partner ☐ Yes, same sex partner

Have you ever had a sexually transmitted infection (**STI**) or sexually transmitted disease (**STD**)?

☐ Yes ☐ No

If yes, please list date and type____

Musculoskeletal:

Do you have **arthritis**? ☐ Yes ☐ No

Do you have **rheumatoid arthritis**? ☐ Yes ☐ No

Do you currently experience **chronic joint pain** (not muscle)? ☐ Yes ☐ No

Do you currently have **chronic muscle pain** (not joint)? ☐ Yes ☐ No

Do you have **osteopenia**? ☐ Yes ☐ No

If yes, what treatment do you use? ____

Do you have **osteoporosis**? ☐ Yes ☐ No

If yes, what treatment do you use? ____

Skin:

Have you ever had **skin cancer**? ☐ Yes ☐ No

If yes, what treatment did you receive? ____

Do you suffer from **hair loss** or **thinning of your hair**? ☐ Yes ☐ No

Do you suffer from or have you had severe **acne**? ☐ Yes ☐ No

Do you have **rosacea**? ☐ Yes ☐ No

If yes, what treatment do you use? ____

Do you have **scleroderma**? ☐ Yes ☐ No

If yes, what treatment do you use? ____

Do you have any other **skin conditions**? ☐ Yes ☐ No

If yes, what is the condition? ____

What treatment do you use? ____

Hematology:

Are you currently or have ever been **anemic** (low red blood cells)? ☐ Yes ☐ No

Have you ever had a **blood transfusion**? ☐ Yes ☐ No

If yes, for what reason? ____

Have you ever had or experienced a **blood clot(s)** anywhere in your body?

If yes, where was the blood clot? ____

What treatment did you receive? ____

Have you ever been diagnosed with **Hepatitis**? ☐ Yes ☐ No

If yes, what type? ☐ Hepatitis A ☐ Hepatitis B ☐ Hepatitis C

☐ Other ___________________

Have you ever been diagnosed with **leukemia**? ☐ Yes ☐ No

Have you ever been diagnosed with **lymphoma**? ☐ Yes ☐ No

Have you ever been diagnosed with **multiple myeloma**? ☐ Yes ☐ No

Autoimmune:

Have you ever been diagnosed with the following **autoimmune** disorder?

☐ Lupus ☐ Connective Tissue Disorder ☐ Fibromyalgia

If yes to any of the above, what treatment do you use? _____________________________

Do you suffer from **chronic pain**? ☐ Yes ☐ No

If yes, what treatment do you use? ____

Specialty procedures or treatments:

Have you had any other **radiation**, **chemotherapy**, or **specialized treatment** not listed previously?

If yes, please list year and describe: ____

____

Psychiatric/Mood:

Have you ever been diagnosed or suffer from the following?

☐ Anxiety ☐ Depression ☐ Bipolar ☐ Manic episodes ☐ Panic attacks

☐ Schizophrenia ☐ OCD ☐ Other: ____________________________

Have you ever had or currently suffer from an **eating disorder**?

If yes, please explain ____

Please list any other specific **mental health conditions** or information you would like to share:

____

____

Social History:

Marital status: ☐ Single ☐ Married (opposite sex partner) ☐ Married (same sex partner)
☐ Living with significant other ☐ Divorced ☐ Widowed

Are you employed? ☐ No ☐ Yes If yes, where? ______________________________________

Are you exposed to hazardous chemicals at your work? ☐ No ☐ Yes

If yes, please list: ____

Do you use caffeine? ☐ No ☐ Yes If yes: Type _____________________ How much? _________

Have you ever or are currently using tobacco/nicotine products (cigarettes, cigars, chew, vaping/smokeless, patches)? ☐ No ☐ Yes ☐ Quit

If yes, Type? _______________________ How long (months, years)? ______________

If quit, Year quit _____________ What product? ____________________ How long? _______

Exposed to secondhand smoke? ☐ No ☐ Yes If yes, by whom? _____________________________

Do you use or have ever used recreational drugs (marijuana, cocaine, meth, etc.)? ☐ No ☐ Yes

If yes; ☐ CBD with THC ☐ Marijuana/Cannabis ☐ Delta-8 ☐ Cocaine ☐ Meth ☐ Heroin ☐ Other, ________________________

If currently using, For how long? ____________

If used in the past, what drug(s)? __________________________ For how long? ____________

Do you use alcohol? ☐ No ☐ Yes If yes, what type (beer, wine, liquor, etc.)? ________________
How often (number per day, week, or month)? ______________________________________

Surgical History:

Surgery or Procedure	Year (closest date or year)

Family History:

Diagnosis / Condition	Yes	No	What family member?
Breast Cancer			
Colon Cancer			
Ovarian Cancer			
Cervical or Endometrial Cancer			
Prostate cancer			
Osteoporosis			
Diabetes			
Hypertension			
Heart Disease			
Kidney Disease			
Lung Disease			
Other:			

Allergies:
Please list ALL allergies (medication and non-medication).

Medication/Non-medication	Reaction

Medications:

Please list ALL prescription, non-prescription and supplements you are currently taking (including herbal supplements, essential oils, hormones, etc.).

Please attach an additional list if needed.

Medication	Dose/ Amount	How Often	Reason for Taking	Provider/OTC