Date:_______________

MALE 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 Voicemail : (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, or Care Credit.

Patient Name:____ **DOB:**_______________

Height: ___________ **Weight** ____________

Habits: Alcohol: Y _____ N _____ Daily Exercise: Y ______ N ______

Smoke: Y: Currently, _______ packs per day. Only Socially ________

N: I quit ______ years ago Never have _________

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/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:____

Notes:

____
____
____
____
____