

Last Name: _____ First Name: _____ DOB: _____

Age: _____ Male _____ Female _____ SSN: _____ Occupation: _____

Mailing Address: _____ City: _____ State: _____ Zip: _____

Cell Phone: _____ Home: _____ Work: _____

Email: _____ Join our email list: yes no

Emergency Contact: _____ Relationship: _____ Phone: _____

Referring Physician: _____ Eye Doctor: _____ Date of last eye exam: _____

Family Physician: _____ Date of last physical exam: _____

How did you hear about us? ___ Newspaper ___ TV Commercial ___ Internet ___ Website ___ Phonebook
___ Facebook ___ Instagram _____ Friend/Family _____ Other

Are you currently being treated by a psychiatrist/psychologist? ___ No ___ Yes Whom: _____

Have you ever consulted with another physician regarding cosmetic surgery? ___ No ___ Yes Whom: _____

Do you realize that every operative procedure is followed by a period of healing before tissues return to normal and a final result is apparent? ___ Yes ___ No

Do you understand that carefully following instructions on pre-operative and post-operative care along with avoiding sun exposure, tobacco and alcohol use, use of blood thinners such as aspirin, Motrin, etc. are paramount in healing and your final result? ___ Yes ___ No

Have you ever taken Accutane? ___ No ___ Yes When: _____

Do you smoke? ___ No ___ Yes How many packs per day: _____ How many years: _____

Do you take aspirin or blood thinners? ___ No ___ Yes What medication: _____

Have you ever consulted with an attorney or threatened malpractice lawsuit against any doctor, surgeon, or other healthcare provider? ___ No ___ Yes Details: _____

I understand that all services provided through Skin Secrets within the Allergy Ear, Nose & Throat Institute are strictly on a cash basis. Services provided are considered elective and cosmetic and are not covered by healthcare insurance. If for any reason, you feel that a service you are requesting might be covered by insurance or another third party or worker's compensation, you must notify us of this now. I have plans to request services from healthcare insurance, a third party, or worker's compensation. ___ Yes ___ No

I understand photographs of my face and other body areas may be taken and maintained in my file as part of my medical record, and I hereby give consent for the photographs to be taken, stored and used in my treatment. I understand my photos will not be released to another person or entity without my written consent.

I understand my consultation fee of \$75.00 is non-refundable and will go towards a service given within 90 days.

Signature: _____ Date: _____

Parent/Legal Guardian (if patient is under 18 years of age): _____ Date: _____

PATIENT HISTORY FORM

GENERAL INFORMATION

Patient's Name _____ Age _____ Sex _____ Date _____

Cosmetic Concerns (Why you came to see the doctor today)

- 1) _____
- 2) _____
- 3) _____

Prior cosmetic procedures you have had (type of procedure, doctor, date)

- 1) _____
- 2) _____
- 3) _____

PAST MEDICAL HISTORY

Review of Systems (Problems you currently have or have been diagnosed with in the past) Please mark all boxes (No/Yes) and add details in blanks.

1) Constitutional

- No Yes
- Weight Loss _____
- Weight Gain _____
- Chronic Fever _____
- Anesthetic Reaction _____
- Birth Complications _____
- Childhood Illness _____

2) Eyes

- No Yes
- Visual Problems _____
- Double Vision _____

3) Head/Ear Nose & Throat

- No Yes
- Ear Infections _____
- Ear Pain _____
- Hearing Loss _____
- Ringing in Ears _____
- Ear Drainage _____
- Dizziness _____
- Sinus Infections _____
- Smell & Taste Disorder _____
- Nasal Obstruction _____
- Nasal Polyps _____
- Nose Bleeds _____
- Dental Problems _____
- TMJ Syndrome _____
- Hoarseness _____
- Swallowing Problems _____
- Neck Mass/Swelling _____
- Snoring _____
- Apnea _____
- Other _____

4) Cardiovascular

- No Yes
- Rheumatic Fever _____
- Heart Problems _____
- Strokes _____
- TIA's _____
- Irregular Heart Beat _____
- High Blood Pressure _____
- Chest Pain _____

5) Respiratory

- No Yes
- Chronic Cough _____
- COPD _____
- Asthma _____
- Shortness of Breath _____

6) Gastrointestinal

- No Yes
- Stomach Ulcers _____
- Heartburn/Acid Reflux _____
- Hepatitis _____
- Hiatal Hernia _____
- Food Sensitivity _____

7) Genitourinary

- No Yes
- Kidney Problems _____
- Kidney Infection _____

8) Musculoskeletal

- No Yes
- Muscle / Joint Pain _____
- Neck Pain _____
- Back Pain _____

9) Integument

- No Yes
- Skin Problems _____
- Skin Lesion _____
- MRSA _____

10) Neurologic

- No Yes
- Head Injury _____
- Seizures _____
- Headaches _____
- Loss of Consciousness _____

11) Psychiatric

- No Yes
- Emotional Disorder _____
- Attention Deficit Disorder _____
- PTSD _____

12) Endocrine

- No Yes
- Diabetes _____
- Thyroid Disease _____

13) Hematologic – Lymphatic

- No Yes
- Easy Bleeding / Bruising _____
- Cancer _____
- Enlarged Lymph Nodes _____
- Blood Disease _____

14) Allergic – Immunologic

- No Yes
- Allergies _____
- Hay Fever _____
- Hives _____
- AIDS / HIV Positive _____

Medical History (List medical illnesses, chronic conditions, and hospitalizations you have had)

NO MEDICAL HISTORY

	Diagnosis	Treatment	Doctor	Date of Diagnosis
1)				
2)				
3)				
4)				
5)				
6)				
7)				
8)				
9)				
10)				

Surgical History (List any surgeries that you have had)

Have you been told to take antibiotics before surgery or dental work? YES NO

NO SURGICAL HISTORY

	Surgery Diagnosis	Doctor	Date of
1)			
2)			
3)			
4)			
5)			
6)			
7)			
8)			
9)			
10)			

Current Medications (List all prescribed medications as well as all "over-the-counter" medications, vitamins, herbals and supplements)

NOT TAKING ANY MEDICATIONS

	Name of Drug	Reason Taken	Dose/Duration	Date Started
1)				
2)				
3)				
4)				
5)				
6)				
7)				
8)				
9)				
10)				

Medication Reactions / Allergies (List each reaction which has occurred)

NO KNOWN ALLERGIES **LATEX ALLERGY?** YES NO

Medication / Substance

Reaction

Date of Occurrence

- 1) _____
- 2) _____
- 3) _____
- 4) _____
- 5) _____
- 6) _____
- 7) _____
- 8) _____
- 9) _____
- 10) _____

Family History (Please mark all boxes and add details in blanks regarding health status or cause of death in immediate family)

- | | | |
|--|--|--|
| <input type="checkbox"/> Heart Disease _____ | <input type="checkbox"/> Anesthetic Reaction _____ | <input type="checkbox"/> Hereditary Diseases _____ |
| <input type="checkbox"/> High Blood Pressure _____ | <input type="checkbox"/> Deafness _____ | <input type="checkbox"/> Cancer _____ |
| <input type="checkbox"/> Diabetes _____ | <input type="checkbox"/> Allergy _____ | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Stroke _____ | <input type="checkbox"/> Hay Fever _____ | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Bleeding Disorder _____ | <input type="checkbox"/> Asthma _____ | <input type="checkbox"/> _____ |
| _____ | <input type="checkbox"/> Thyroid Disorder _____ | <input type="checkbox"/> _____ |
| _____ | <input type="checkbox"/> Kidney Disease _____ | |

Social History (List all that apply)

Chemical / Mold Exposure? YES NO

Duration

When Stopped

- 1) Tobacco use _____
- 2) Alcohol use _____
- 3) Street Drug Use _____

Patient Signature _____ Date _____