PATIENT INTAKE & MEDICAL HISTORY

Patient identification and contact

Patient Identification

Legal first name

Middle initial

Last name

Preferred name (if different)

Date of birth (MM/DD/YYYY)

Age

Sex assigned at birth

- [ ] Female
- [ ] Male

Gender identity

- [ ] Female
- [ ] Male
- [ ] Non-binary
- [ ] Other

Preferred pronouns

Preferred title / honorific

Address

Country

- [ ] USA
- [ ] Other country

Home address

Apartment / suite

City

State / province

ZIP / postal code

Marital status

Occupation

Employer

PATIENT INTAKE & MEDICAL HISTORY

Communication and emergency contact

Communication

Email address

Best phone number to reach you

Phone type

- [ ] Mobile
- [ ] Home
- [ ] Work

Alternate phone (optional)

Alternate phone type

- [ ] Mobile
- [ ] Home
- [ ] Work

May we leave a voicemail containing personal or health information?

- [ ] Yes
- [ ] No

Allow text messages and/or emails for appointment reminders?

- [ ] Yes
- [ ] No

Permit the office to communicate private health information through provider and office staff?

- [ ] Yes
- [ ] No

Receive marketing offers or office news by text?

- [ ] Yes
- [ ] No

Receive marketing offers or office news by email?

- [ ] Yes
- [ ] No

Emergency Contact

Emergency contact name

Relationship to you

Emergency contact phone

PATIENT INTAKE & MEDICAL HISTORY

Allergies or adverse reactions

Allergies or Adverse Reactions

It is critically important for your safety to list ALL allergies to medications.

Do you have any allergies or adverse reactions to latex?

☐ Yes ☐ No

Do you have any allergies or adverse reactions to adhesive tape?

☐ Yes ☐ No

Have you had any adverse reactions to anesthesia?

☐ Yes ☐ No

Do you have any allergies or adverse reactions to medications?

☐ Yes ☐ No

List each allergy on a separate line, including the reaction.

Medication / substance	Type of reaction	Comments (optional)

PATIENT INTAKE & MEDICAL HISTORY

Consultation and care providers

Reason for Consultation

What procedure or treatment(s) are you interested in?

More Information About You

Ideal time frame for having the procedure(s)

Interested in learning about financing options?

- [ ] Yes
- [ ] No

Pharmacy name, address and phone number

Personal history of blood clots, cancer or heart conditions

Family history of blood clots, cancer or heart conditions

Other services you would like to learn about (select all that apply)

- [ ] Botox
- [ ] Dermal fillers
- [ ] Skin care
- [ ] Facials / chemical peels

None of these services at this time

- [ ] None

Medical Care Providers

Who is your primary care doctor?

PATIENT INTAKE & MEDICAL HISTORY

Current medications

Medications

For safe care, list ALL medications, including over-the-counter medications, herbs and supplements.

Preferred pharmacy (include address)

Pharmacy phone number (optional)

Are you currently taking hormonal birth control?

☐ Yes ☐ No

Do you take any medications regularly (including supplements)?

☐ Yes ☐ No

Medication name	Dose / frequency	Reason for taking

PATIENT INTAKE & MEDICAL HISTORY

Surgery and hospitalization history

Past Surgery

Please list ALL past surgeries.

Have you had any prior surgeries?

☐ Yes ☐ No

Name of surgery	Complications or comments	Year

Past Hospitalizations

Have you ever been hospitalized?

☐ Yes ☐ No

If yes, reason(s) and date(s) of hospitalization

PATIENT INTAKE & MEDICAL HISTORY

Height, weight and medical history

Your Height and Weight

Height (feet and inches)

Weight (pounds)

Female Health

Are you planning to have a breast procedure?

☐ Yes ☐ No

Medical History

Do you have or have you ever had any of these medical conditions? Select Yes or No for each and use the comments field as needed.

High cholesterol

☐ Yes ☐ No

Radiation treatments

☐ Yes ☐ No

Recent weight loss

☐ Yes ☐ No

Swelling of limbs

☐ Yes ☐ No

Tumor or growths

☐ Yes ☐ No

Dry eyes

☐ Yes ☐ No

Glaucoma

☐ Yes ☐ No

Cold sores / fever blisters

☐ Yes ☐ No

Medical history comments or details

Medical Conditions

For your safety, list all active medical conditions, one per line.

Active condition	Details / treatment (optional)

Social History

Do you vape, smoke cigars or cigarettes, or have you smoked in the past?

☐ Yes ☐ No

Do you drink alcohol regularly?

☐ Yes ☐ No

Do you use marijuana or medical marijuana?

☐ Yes ☐ No

Do you use recreational drugs?

☐ Yes ☐ No

Additional social history or comments

PATIENT INTAKE & MEDICAL HISTORY

Family history

Family Information

Has anyone in your family had bleeding problems or problems with blood clots?

☐ Yes ☐ No

Has anyone in your family had problems with general anesthesia?

☐ Yes ☐ No

Describe any other important family medical history

PATIENT INTAKE & MEDICAL HISTORY

Acknowledgment and signature

Signature and Acknowledgment

By selecting the agreement checkbox and signing below, I confirm my answers are accurate to the best of my knowledge. I understand that providing incorrect information can be dangerous to my (or the patient's) health. It is my responsibility to inform the office of changes in medical status.

I agree to the above acknowledgment

☐ I agree

Type full legal name as signature

Date signed (MM/DD/YYYY)

Patient / authorized representative

Note: A typed signature is provided for convenience. Ask the receiving office whether an electronic typed signature is accepted for this form.

PATIENT INTAKE & MEDICAL HISTORY

Review of Systems - Part 1

Review of Systems

Select Yes or No for each question. Use the additional details field if relevant.

AIDS/HIV Positive	☐ Yes	☐ No
Alzheimer's Disease	☐ Yes	☐ No
Anaphylaxis	☐ Yes	☐ No
Anemia	☐ Yes	☐ No
Are you now pregnant?	☐ Yes	☐ No
Arthritis/Gout	☐ Yes	☐ No
Artificial Heart Valve	☐ Yes	☐ No
Artificial Joint	☐ Yes	☐ No
Asthma	☐ Yes	☐ No
Blood Disease	☐ Yes	☐ No
Blood Transfusion	☐ Yes	☐ No
Blood Transmissible Disorders	☐ Yes	☐ No
Breathing Problems	☐ Yes	☐ No
Bruise Easily	☐ Yes	☐ No
Cancer	☐ Yes	☐ No
Chemotherapy	☐ Yes	☐ No
Chest Pains	☐ Yes	☐ No
Cold Sores/Fever Blisters	☐ Yes	☐ No
Congenital Heart Disorder	☐ Yes	☐ No
Convulsions	☐ Yes	☐ No
Cortisone Medicine	☐ Yes	☐ No
Deep Vein Thrombosis (DVT)	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No
Do you have children? If yes list their ages	☐ Yes	☐ No
Drug Addiction	☐ Yes	☐ No
Dry Eyes	☐ Yes	☐ No
Emphysema	☐ Yes	☐ No
Epilepsy or Seizures	☐ Yes	☐ No
Excessive Bleeding	☐ Yes	☐ No

PATIENT INTAKE & MEDICAL HISTORY

Review of Systems (continued)

Review of Systems

Fainting Spells/Dizziness	☐ Yes	☐ No
Frequent Cough	☐ Yes	☐ No
Frequent Diarrhea	☐ Yes	☐ No
Glaucoma	☐ Yes	☐ No
Have you ever been denied blood donation?	☐ Yes	☐ No

PATIENT INTAKE & MEDICAL HISTORY

Review of Systems - Part 2

Review of Systems

Select Yes or No for each question. Use the additional details field if relevant.

Have you ever had a mammogram? If yes when, and results?	☐ Yes	☐ No
Heart Attack/Failure	☐ Yes	☐ No
Heart Murmur	☐ Yes	☐ No
Heart Pacemaker	☐ Yes	☐ No
Heart Trouble/Disease	☐ Yes	☐ No
Hemophilia	☐ Yes	☐ No
Hepatitis A	☐ Yes	☐ No
Hepatitis B or C	☐ Yes	☐ No
High Blood Pressure	☐ Yes	☐ No
High Cholesterol	☐ Yes	☐ No
Hives or Rash	☐ Yes	☐ No
Hypoglycemia	☐ Yes	☐ No
Irregular Heartbeat	☐ Yes	☐ No
Kidney Problems	☐ Yes	☐ No
Leukemia	☐ Yes	☐ No
Liver Disease	☐ Yes	☐ No
Low Blood Pressure	☐ Yes	☐ No
Lung Disease	☐ Yes	☐ No
Mitral Valve Prolapse	☐ Yes	☐ No
Oral Herpes	☐ Yes	☐ No
Osteoporosis	☐ Yes	☐ No
Parathyroid Disease	☐ Yes	☐ No
Psychiatric Care	☐ Yes	☐ No
Radiation Treatments	☐ Yes	☐ No
Recent Weight Loss	☐ Yes	☐ No
Renal Dialysis	☐ Yes	☐ No
Rheumatic Fever	☐ Yes	☐ No
Sickle Cell Disease	☐ Yes	☐ No
Sinus Trouble	☐ Yes	☐ No

PATIENT INTAKE & MEDICAL HISTORY

Review of Systems (continued)

Review of Systems

Stomach Ulcers	☐ Yes	☐ No
Stomach/Intestinal Disease	☐ Yes	☐ No
Stroke	☐ Yes	☐ No
Swelling of Limbs	☐ Yes	☐ No
Thyroid Disease	☐ Yes	☐ No
Tuberculosis	☐ Yes	☐ No
Tumor or Growths	☐ Yes	☐ No
Yellow Jaundice	☐ Yes	☐ No
Do you have a personal or family history of breast cancer?	☐ Yes	☐ No

PATIENT INTAKE & MEDICAL HISTORY

Review of Systems - Additional details

Additional Details

Use these fields to clarify any Yes responses, including dates, treatment, and relevant history.

Additional details 1

Additional details 2

Additional details 3

Additional details 4

Additional details 5

Additional details 6

Additional details 7

Additional details 8

Additional details 9

Additional details 10

Additional details 11

Additional details 12