

Name: _____ Birth Date: ____/____/____ Age: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home: (____) _____ Work: (____) _____ Cell: (____) _____

E-mail: _____

Emergency Contact: _____ Telephone: (____) _____

Allergies: _____

Who referred you to our clinic? _____

Please put a check mark next to the procedures about which you would like to receive more information:

- | | |
|--|---|
| <input type="checkbox"/> Acne Treatment | <input type="checkbox"/> Brown Spots |
| <input type="checkbox"/> Botox to Flatten and Prevent Wrinkles | <input type="checkbox"/> Sun Damage |
| <input type="checkbox"/> Skin Rejuvenation | <input type="checkbox"/> Broken Capillaries |
| <input type="checkbox"/> Fillers to treat Deep Wrinkles | <input type="checkbox"/> Facial Veins |
| <input type="checkbox"/> Skin Toning or Pore Size Reduction | <input type="checkbox"/> Hormone Balancing |
| <input type="checkbox"/> Facial Redness | <input type="checkbox"/> Body Contouring/Fat Freezing |
| <input type="checkbox"/> Weight Management | |

Please put a check mark next to a past or current medical condition:**Medical History:**

- | | |
|--|--|
| <input type="checkbox"/> Breast Cancer | <input type="checkbox"/> Herpes simplex or fever blisters |
| <input type="checkbox"/> Lupus or other auto-immune deficiency | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Currently Pregnant | <input type="checkbox"/> Scars that turn white or brown |
| <input type="checkbox"/> Bleeding abnormalities | <input type="checkbox"/> Dark spots after pregnancy, skin injury |
| <input type="checkbox"/> Treatment with Accutane in the last year | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> Treatment with Tetracycline in the last 2 weeks | <input type="checkbox"/> Previous Chemical Peels |
| <input type="checkbox"/> Keloid or very thick scarring | <input type="checkbox"/> Previous Laser Resurfacing |
| <input type="checkbox"/> Pulmonary embolism/blood clot | <input type="checkbox"/> Face Lift |
| <input type="checkbox"/> Blood thinning medication | <input type="checkbox"/> Permanent (Tattooed) Makeup |
| <input type="checkbox"/> Coumadin anti-clotting agents | <input type="checkbox"/> Other: |

Please list any medications or herbal supplements that you are currently taking:

PRIVACY PROMISE

UDMPC understands that your medical and health information is personal. Protecting your health information is important. UDMPC practices its privacy policy under the state and national HIPPA laws.

By signing below you are aware of your privacy rights and at your request will be given a copy of the privacy act.

 Patient Signature

 Date