



INTERNAL MEDICINE & PEDIATRICS WELLNESS CENTER
 6038 W. Nordling Loop, Crystal River, FL 34429
 Ph: (352) 563-5070 Fax (352) 795-4322

NAME: _____ TODAY'S DATE: _____ / _____ / _____
Last First Month Day Year

ADDRESS: _____ BIRTH DATE: _____ / _____ / _____
Month Day Year

CITY: _____ STATE: _____ ZIP CODE: _____

Best phone number to contact you regarding your treatment and where we may leave a message:

HOME PHONE: () _____ CELL PHONE: () _____ WORK PHONE: () _____

VIP E-MAIL: _____ How did you hear about us? _____

Primary Care Physician: _____ PCP PHONE NUMBER: _____

Please tell us your main concerns that brought you to our office today:

This information is necessary for your procedure. Please answer yes or no to the following questions:

YES NO

- Are you using any prescribed medications? List _____
- Are you using any herbal medications? List _____
- Do you take oral anti_coagulant (Blood Thining) medication? List: _____
- Are you allergic to any cosmetic ingredients, medications or foods? List: _____

- Are you pregnant or trying to become pregnant?
- Do you use oral contraceptives?
- Do you use hormone replacement therapy?
- Do you smoke? How much? _____ How long? _____
- Do you spend a lot of time outdoors or use a tanning bed often?
- Do you have any tatoos or permanent makeup?

Please check any health problems, past or present:

- | | | |
|--|---|--|
| <input type="checkbox"/> Seizures | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Skin Cancer (Type: _____) |
| <input type="checkbox"/> Hormonal Problems | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Cystic Acne |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Collagen (Lupus) |
| <input type="checkbox"/> Vasovagal Syncope | <input type="checkbox"/> PCOS | <input type="checkbox"/> Autoimmune (Lupus, scleroderma) |
| | | <input type="checkbox"/> Thyroid |
| | | <input type="checkbox"/> Sarcoidosis |
| | | <input type="checkbox"/> Cancer |
| | | <input type="checkbox"/> Hepatitis |
| | | <input type="checkbox"/> Asthma |

Do you have any of the following chronic skin disorders?

- | | | | |
|---|-------------------------------------|---------------------------------------|--|
| <input type="checkbox"/> Psoriasis | <input type="checkbox"/> Dermatitis | <input type="checkbox"/> Exzema | <input type="checkbox"/> Keloid Scarring |
| <input type="checkbox"/> Fever Blisters | <input type="checkbox"/> Cold Sores | <input type="checkbox"/> Sun Blisters | <input type="checkbox"/> Herpes Simplex/Blisters |