



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 |

In addition to the above, please tell us which skin conditions concern you the most (Check all that apply):

- | | | |
|---|---|---|
| <input type="checkbox"/> Uneven Skin Tone | <input type="checkbox"/> Visible Exposed Blood Vessels | <input type="checkbox"/> Hard Bumps Under Skin |
| <input type="checkbox"/> Enlarged Pores | <input type="checkbox"/> Clogged Pores | <input type="checkbox"/> Blackheads/Whiteheads |
| <input type="checkbox"/> Acne | <input type="checkbox"/> Excessive Oiliness | <input type="checkbox"/> Pimples |
| <input type="checkbox"/> Upper lip lines | <input type="checkbox"/> Wrinkles | <input type="checkbox"/> Scarring |
| <input type="checkbox"/> Sun Spots | <input type="checkbox"/> Dry Patches | <input type="checkbox"/> Unwanted Hair |
| <input type="checkbox"/> Sun Damage | <input type="checkbox"/> Brown Spots (Hyperpigmentation) | <input type="checkbox"/> White Spots (Hypopigmentation) |

What is your skin type: Dry Combination Oily Normal

Please check the products you currently use and list the BRAND NAMES of cosmetic products:

- | | | |
|--|--|---|
| <input type="checkbox"/> Cleanser _____ | <input type="checkbox"/> Soap _____ | <input type="checkbox"/> Toner _____ |
| <input type="checkbox"/> Moisturizer _____ | <input type="checkbox"/> Night Cream _____ | <input type="checkbox"/> Mask _____ |
| <input type="checkbox"/> Eye Cream _____ | <input type="checkbox"/> Astringent _____ | <input type="checkbox"/> Glycolic Wash/Cleanser |
| <input type="checkbox"/> Scrub _____ | <input type="checkbox"/> Sunscreen _____ | <input type="checkbox"/> Salicylic Wash/Cleanser |
| <input type="checkbox"/> Vitamin A Cream _____ | <input type="checkbox"/> Vitamin C Creme _____ | <input type="checkbox"/> Alpha or Betahydroxy Cream |

Are you using any topical creams, lotions or oral antibiotics for acne, skin cancer, and anti-aging or hyperpigmentation?

Please List:

Yes No

Have you ever had any of the following wrinkle filters or implants:

- Collagen Restylane Perlane Hylaform Juvederm® Silicone Radiesse

If so, when? _____ What are? _____ By Whom? _____

Have you ever undergone any of the following treatments?

- Cosmetic Surgery What area of the body? _____ When was it done? _____
- BOTOX® What area of the face? _____ When was it done? _____
- Acid Peel Accutane Microdermabrasion Lasers Which one? _____
- When and where was it done? _____

Are currently removing hair by any of the following methods?

- Waxing Tweezing "Nair" type products Electrolysis Laser Hair Removal

If so, when? _____ What area? _____ What type of laser _____

I certify that the above information is correct to the best of my knowledge. _____

Patient Signature

IM&P Wellness Center Notes:



SKIN TYPING WORKSHEET

SCORE	0	1	2	3	4
What is the color of your eyes?	<input type="checkbox"/> Light Blue, Gray, Light Green	<input type="checkbox"/> Blue, Gray or Green	<input type="checkbox"/> Dark Blue or Hazel	<input type="checkbox"/> Dark Brown	<input type="checkbox"/> Brownish Black
What is the natural color fo your hair?	<input type="checkbox"/> Sandy Red	<input type="checkbox"/> Blonde	<input type="checkbox"/> Chestnut, Dark Blonde	<input type="checkbox"/> Dark Brown	<input type="checkbox"/> Black
What is the color of your skin? <i>(Non-exposed areas)</i>	<input type="checkbox"/> Reddish	<input type="checkbox"/> Very Pale	<input type="checkbox"/> Pale with Beige Tint	<input type="checkbox"/> Light Brown	<input type="checkbox"/> Dark Brown
Do you have freckles on unexposed areas?	<input type="checkbox"/> Many	<input type="checkbox"/> Several	<input type="checkbox"/> Few	<input type="checkbox"/> Incidental	<input type="checkbox"/> None

Total score for GENETIC DISPOSITION _____

SCORE	0	1	2	3	4
What happens when you stay in the sub too long?	<input type="checkbox"/> Painful red-ness, blistering, peeling	<input type="checkbox"/> Blistering follo-woed by peeling	<input type="checkbox"/> Burns some-times followed by peeling	<input type="checkbox"/> Rare Burns	<input type="checkbox"/> Never had burns
To what degree do you turn brown?	<input type="checkbox"/> Hardly or not at all	<input type="checkbox"/> Light color tan	<input type="checkbox"/> Reasonable tan	<input type="checkbox"/> Tans easily	<input type="checkbox"/> Turns dark brown quickly
Do you turn brown after several houes of sun exposure?	<input type="checkbox"/> Never	<input type="checkbox"/> Seldom	<input type="checkbox"/> Sometimes	<input type="checkbox"/> Often	<input type="checkbox"/> Always
How does your face react to the sun?	<input type="checkbox"/> Very sensitive	<input type="checkbox"/> Sensitive	<input type="checkbox"/> Normal	<input type="checkbox"/> Very resistant	<input type="checkbox"/> Never had a problem

Total score for REACTION TO SUN EXPOSURE _____

SCORE	0	1	2	3	4
When was the last time you exposed your body to the sun too long?	<input type="checkbox"/> More than 3 months ago	<input type="checkbox"/> 2-3 months ago	<input type="checkbox"/> 1-2 months ago	<input type="checkbox"/> Less than a month ago	<input type="checkbox"/> Less than 2 weeks ago
How frequently do you expose the area to be treated to the sun?	<input type="checkbox"/> Never	<input type="checkbox"/> Hardly ever	<input type="checkbox"/> Sometimes	<input type="checkbox"/> Often	<input type="checkbox"/> Always

SUMMARY

Total score for Genetic Disposition _____

Total score for Reaction to Sun _____

Total score for Tanning Habits _____

Total score for _____

Your Fitzpatrick Skin Type	
Skin type score	Fitzpatrick Skin Type
0-7	I
8-16	II
17-25	III
25-30	IV
Above 30	V-VI



Hair & Vein Removal • Sun Spot Removal • Restylane • Botox • Skin Care

COSMETIC POLICIES

Name: _____

Please read and initial each paragraph signifying you understand the following policies.

_____ I have been notified and fully informed that the procedure to be done is a cosmetic procedure as defined by the insurance industry. I understand that Cosmetic procedures/services are determined to be "not medically necessary". This procedure cannot be filed with any insurance company for payment or reimbursement by myself or any other party. I hereby agree to be held personally and fully responsible for payment of entire procedure at the above cost/expenses.

_____ I understand that cosmetic procedures are not an exact science. Although our staff strives for the best results with all treatments, the efficacy may vary among individuals. I may see excellent results, partial results, or no results. Refunds will not be requested or expected by me.

_____ In fairness to other clients who are waiting to receive scheduled appointments, I agree to provide a full 48 hours advanced notice if I am unable to keep my appointment. I understand that missed appointments or cancellations with less than 48 hours notice will incur a \$50 fee.

_____ I understand that children and guests are not permitted in any procedure room for any reason due to significant medical and safety risk. Children under 10yrs. old are not permitted unattended in the waiting room at any time. Staff members are not permitted to supervise children.

_____ I have read and understand the consent(s) form(s) pertaining to my procedure(s) I agree to hold harmless and release from any liability IM&P Wellness Center or any of it's officers, or employees for any condition or result, known or unknown that may arise as a result of any treatment that I receive.

_____ I understand photos will be taken before, during and after any procedure for documentation in my medical record.

_____ I am aware that Dr. Wilson is speaker, trainer and educator for medical procedures and that she may want to use my photos for medical education of other physicians in lectures, power point presentations and research. I agree to allow Dr. Wilson to use my photos in the following way: (Please check all that apply) Chart use only In-office use before/after photo book Unrestricted use.

_____ Under Florida Law, physicians are generally required to carry medical malpractice insurance or otherwise demonstrate financial responsibility to cover potential claims for medical malpractice. YOUR DOCTOR HAS DECIDED NOT TO CARRY MEDICAL MALPRACTICE INSURANCE. This is permitted under Florida law subject to certain conditions. Florida law imposes penalties against noninsured physicians who fail to satisfy adverse judgments arising from claims of medical malpractice. This notice is provided pursuant to Florida Law. By initialing, I acknowledge that I have read this form, that I fully understand its contents, and that I have been given ample opportunity to ask questions and that all my questions have been answered to my satisfaction.

I have read and understand the above stated policies.

Patient

Witness

Date_____