



PATIENT INFORMATION

Full Name: _____ Date: _____
Day/Month/Year

Date of Birth: _____
Day/Month/Year

Gender: Male Female Transgendered

Ethnicity: _____

CONTACT INFORMATION

Full Address: _____

Telephone: (home) _____ (work) _____
(mobile) _____

Email: _____

Emergency Contact: _____

Relationship: _____

(_____) _____ (_____) _____ (_____) _____
Telephone (home) Work Mobile / Pager

Marital Status (circle): Single Married Divorced Separated Living with Partner Widowed

Do you have any children? Y N

If yes, list age and gender. _____

Name of Medical Doctor: _____ Tel: (_____) _____

Address: _____ Fax:(_____) _____

Date of last visit to Medical Doctor: _____ Date last physical: _____

Are you under the care of any other health care providers (Please list names, specialty, phone number)?

How did you hear of this clinic/who were you referred by? _____

Occupation?
Any occupational hazards?

MEDICAL HISTORY

Please list your chief health concerns and current medical conditions.

Concern	Since
1.	
2.	
3.	
4.	

Please describe the concerns and desired outcomes you have regarding your face and/or skin's appearance:

Please list any surgical procedures (cosmetic or otherwise) you have undergone.

Procedure	Date	Complications / Results

Please list any other forms of treatment that you have used and describe their effectiveness:

How would you describe your general state of health?

Please list any major trauma, injury, illness or accident (mental, emotional or physical) you have sustained.

Incident	Date	Long-term effects

CHILDHOOD ILLNESSES & VACCINATIONS:(circle all that apply & indicate “I” for illness & “V” for vaccination):

Chicken pox	Measles	Mumps	Rheumatic Fever	Roseola
Polio	Scarlet fever	Tuberculosis	Whooping Cough	Impetigo
Ear Infections	Strep Throat	Mononucleosis	Rubella (German measles)	

Followed childhood vaccination schedule?
Any known side effects to any vaccinations?

Any additional vaccinations (i.e. Hepatitis A or B, “Flu shot”, etc)?

MEDICATIONS / SUPPLEMENTS / DRUGS

Please list all **current** medications and supplements you take including prescription drugs, over the counter drugs, herbs, vitamins, minerals, homeopathics, etc.

Drug / Supplement (Company & Brand Name)	Used For	Date Started	Dosage / Frequency

In the last 5 years, about how many courses of antibiotics have you taken?
Most recent course?

Which of the following have you used / do your currently use? Include amount, frequency, duration.

Tobacco	Alcohol
Recreational Drugs	Steroids
Cortisone	Antacids
Sedatives	Laxatives
Coffee	Other

ALLERGIES, SENSITIVITIES, EXPOSURES

Please list any known or suspected allergies, sensitivities and/or intolerances.

Drugs	Food	Environmental/Chemical

FAMILY HISTORY

Please indicate if any of your immediate family (parents, siblings, maternal & paternal grandparents) suffers from or has suffered from any of the following conditions.

Condition	Family Member(s)	Condition	Family Member(s)	Condition	Family Member(s)
Alcoholism/ Drug use		Colitis		Kidney Disease	
Allergies / hay fever		Depression/ mental health		Liver Disease	
Asthma		Diabetes		Overweight / obesity	
Arthritis		Heart Disease		Osteoporosis	
Breast Cancer		High Blood Pressure		Prostate Cancer	
Colon Cancer		Thyroid disease		Stroke	

Any other conditions?

How much time do you typically spend in the sun:

With sunscreen?

Without sunscreen?

What SPF do you typically use and how often do you apply/reapply?

What is your current skin care regimen?

REVIEW OF SYSTEMS

Lifestyle Habits

Stress Level?

Regular Exercise?

Type?

Frequency?

Duration?

General Symptoms Please check all that apply.

- | | | | |
|---|---|---|---|
| <input type="checkbox"/> Poor appetite | <input type="checkbox"/> Difficulty falling sleep | <input type="checkbox"/> Sensation of heaviness | <input type="checkbox"/> Chills |
| <input type="checkbox"/> Bleed or bruise easily | <input type="checkbox"/> Peculiar taste | <input type="checkbox"/> Insatiable appetite | <input type="checkbox"/> Heavy sleep |
| <input type="checkbox"/> Cold hands or feet | <input type="checkbox"/> Night sweats | <input type="checkbox"/> Prefer cold drinks | <input type="checkbox"/> Dream disturbed sleep |
| <input type="checkbox"/> Muscle cramps | <input type="checkbox"/> Sweat easily | <input type="checkbox"/> Prefer hot drinks | <input type="checkbox"/> Fatigue |
| <input type="checkbox"/> Lack of strength | <input type="checkbox"/> Fever | <input type="checkbox"/> Strong Thirst | <input type="checkbox"/> Little / absent thirst |

Head, Eyes, Ears, Nose, Throat

- | | | | |
|---|---|---|---|
| <input type="checkbox"/> Impaired vision | <input type="checkbox"/> Night blindness | <input type="checkbox"/> Sores on lips or tongue | <input type="checkbox"/> Recurrent sore throat |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Eye strain | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Dry mouth |
| <input type="checkbox"/> Swollen glands | <input type="checkbox"/> Migraines | <input type="checkbox"/> Eye pain | <input type="checkbox"/> Cataracts |
| <input type="checkbox"/> Excessive saliva | <input type="checkbox"/> Lumps in throat | <input type="checkbox"/> Concussions | <input type="checkbox"/> Red eyes |
| <input type="checkbox"/> Teeth problems | <input type="checkbox"/> Sinus problems | <input type="checkbox"/> Enlarged thyroid | <input type="checkbox"/> other head/neck problems |
| <input type="checkbox"/> Itchy eyes | <input type="checkbox"/> Grinding teeth | <input type="checkbox"/> Excessive phlegm | <input type="checkbox"/> Nose bleeds |
| <input type="checkbox"/> Spots in eyes | <input type="checkbox"/> Jaw pain/tension | <input type="checkbox"/> Colour /texture of phlegm: _____ | |
| <input type="checkbox"/> Ringing in ears | <input type="checkbox"/> Poor vision | <input type="checkbox"/> Facial pain | <input type="checkbox"/> Poor hearing |
| <input type="checkbox"/> Blurred vision | <input type="checkbox"/> Gum problems | <input type="checkbox"/> Ear aches | <input type="checkbox"/> Vertigo or dizziness |

Respiratory

- | | | | |
|---|--|---|---|
| <input type="checkbox"/> Difficulty breathing
when laying down | <input type="checkbox"/> Tight chest | <input type="checkbox"/> Productive Cough | <input type="checkbox"/> Coughing blood |
| <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Asthma/wheezing | <input type="checkbox"/> Dry cough | <input type="checkbox"/> Pneumonia |
| | <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Soft voice | <input type="checkbox"/> Loud voice |

Cardiovascular

- | | | | |
|--|--|--|---|
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Low blood pressure | <input type="checkbox"/> Chest pain | <input type="checkbox"/> Rapid/racing pulse |
| <input type="checkbox"/> Phlebitis | <input type="checkbox"/> Blood clots | <input type="checkbox"/> Fainting | <input type="checkbox"/> Difficulty breathing |
| <input type="checkbox"/> Heart palpitations | <input type="checkbox"/> Irregular heartbeat | <input type="checkbox"/> Edema/water retention | <input type="checkbox"/> Heart disease |

Gastrointestinal

- | | | | |
|---|--|---|---------------------------------------|
| <input type="checkbox"/> Nausea | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Intestinal pain/cramps | <input type="checkbox"/> Constipation |
| <input type="checkbox"/> Bowel movements:
Odor _____ | Frequency _____ | Colour _____ | Texture/form _____ |
| <input type="checkbox"/> Vomiting | <input type="checkbox"/> Itchy anus | <input type="checkbox"/> Acid regurgitation | <input type="checkbox"/> Laxative use |
| <input type="checkbox"/> Burning anus | <input type="checkbox"/> Gas | <input type="checkbox"/> Black stools | <input type="checkbox"/> Rectal pain |
| <input type="checkbox"/> Hiccup | <input type="checkbox"/> Bloody stools | <input type="checkbox"/> Hemorrhoids | <input type="checkbox"/> Bloating |
| <input type="checkbox"/> Mucous in stools | <input type="checkbox"/> Anal fissures | <input type="checkbox"/> Bad breath | |

Musculoskeletal

- | | | | |
|---|--|-------------------------------------|---|
| <input type="checkbox"/> Neck/shoulder pain | <input type="checkbox"/> Upper back pain | <input type="checkbox"/> Joint pain | <input type="checkbox"/> Limited movement |
| <input type="checkbox"/> Muscle pain | <input type="checkbox"/> Low back pain | <input type="checkbox"/> Rib pain | <input type="checkbox"/> Limited use |

Other (describe) _____



Skin and Hair

- | | | | |
|--------------------------------------|------------------------------------|------------------------------------|--|
| <input type="checkbox"/> Rashes | <input type="checkbox"/> Eczema | <input type="checkbox"/> Dandruff | <input type="checkbox"/> Change in hair/skin |
| <input type="checkbox"/> Hives | <input type="checkbox"/> Psoriasis | <input type="checkbox"/> Itching | <input type="checkbox"/> Fungal infections |
| <input type="checkbox"/> Ulcerations | <input type="checkbox"/> Acne | <input type="checkbox"/> Hair loss | <input type="checkbox"/> Other hair/skin problems: |
-

Neuropsychological

- | | | | |
|---------------------------------------|--------------------------------------|--|---|
| <input type="checkbox"/> Seizures | <input type="checkbox"/> Poor memory | <input type="checkbox"/> Irritability | <input type="checkbox"/> Considered or |
| <input type="checkbox"/> Numbness | <input type="checkbox"/> Depression | <input type="checkbox"/> Easily stressed | <input type="checkbox"/> attempted suicide |
| <input type="checkbox"/> Tics | <input type="checkbox"/> Anxiety | <input type="checkbox"/> Abuse survivor | <input type="checkbox"/> Seeing a therapist |
| <input type="checkbox"/> Other: _____ | | | |
-

Genito-urinary

- | | | | |
|--|--|---|---|
| <input type="checkbox"/> Pain on urination | <input type="checkbox"/> Blood in urine | <input type="checkbox"/> Increased libido | <input type="checkbox"/> Sexually transmitted infection |
| <input type="checkbox"/> Impotence | <input type="checkbox"/> Frequent urination | <input type="checkbox"/> Unable to hold urine | <input type="checkbox"/> Bedwetting |
| <input type="checkbox"/> Decreased libido | <input type="checkbox"/> Premature ejaculation | <input type="checkbox"/> Urgent urination | <input type="checkbox"/> Incomplete urination |
| <input type="checkbox"/> Wake to urinate | <input type="checkbox"/> Kidney stone | <input type="checkbox"/> Nocturnal emission | |

Gynecology

- | | | | |
|--|---|---|--|
| <input type="checkbox"/> Age menses began: _____ | <input type="checkbox"/> Duration of flow (days): _____ | <input type="checkbox"/> Length of cycle (day 1 - day 1): _____ | |
| <input type="checkbox"/> colour of blood: _____ | <input type="checkbox"/> Date last period began: _____ | <input type="checkbox"/> Date last PAP: _____ | |
| <input type="checkbox"/> Vaginal discharge | <input type="checkbox"/> Breast lumps | <input type="checkbox"/> Irregular periods | <input type="checkbox"/> Vaginal sores |
| <input type="checkbox"/> Painful periods | <input type="checkbox"/> Vaginal odor | <input type="checkbox"/> PMS | <input type="checkbox"/> Clots |
| <input type="checkbox"/> # Pregnancies _____ | <input type="checkbox"/> # live births _____ | <input type="checkbox"/> Premature births _____ | |
| <input type="checkbox"/> Age at menopause _____ | Other: _____ | | |
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Is there any chance you are pregnant now? Y N

Are you currently lactating? Y N

Is there any additional information relevant to your health that you would like to provide?