NEW PATIENT INFORMATION

PATIENT NAME: _____ **DATE OF VISIT:** _____

REASON FOR VISIT: _____

PERSONAL INFORMATION

Date of Birth: _____ Age: _____ Gender: Male ( ) Female ( ) SS#: _____

Home Address: _____ City/State/Zip: _____

Mailing Address_____ City/State/Zip: _____

Cell Phone: _____ Is it okay for us to contact you or leave a message on this number? Yes ( ) No ( )

Home Phone: _____ Is it okay for us to contact you or leave a message on this number? Yes ( ) No ( )

Work Phone: _____ Is it okay for us to contact you or leave a message on this number? Yes ( ) No ( )

Email: _____ May we send you specials via email? Yes ( ) No ( )

Are you amenable to receiving appointment reminders via TEXT_____ or EMAIL _____?

If TEXT, please provide name of mobile provider_____

Employer: _____Occupation: _____

Emergency contact: _____ Relationship: _____

Home/Cell Phone: _____Work Phone: _____

FAMILY

Marital Status: ( ) Single ( ) Married ( ) Divorced ( ) Widow ( ) Partner

Spouse Name: _____ Employer/Occupation: _____

Children Names/Ages: _____

If the patient is a minor, Mother's Name: _____ Father's Name: _____

HOW WERE YOU REFERRED TO US? PLEASE BE SPECIFIC

( ) Internet (website): _____ ( ) Ad (source): _____

( ) Doctor (name/address): _____ ( ) Patient (name/address): _____

( ) Other: _____

May we thank the referral source? Yes ( ) No ( )

PHARMACY INFORMATION

Name/location/phone of preferred pharmacy: _____

INSURANCE INFORMATION

Name of Insurance Carrier: _____ Name of Policy Holder: _____

PHYSICIAN INFORMATION

Primary Care Physician: _____

Specialty Physicians: _____

Are you a patient of Austin DermCare? _____ If yes, which physician? _____

MEDICAL & SURGICAL HISTORY (PART 1 of 2)

PLEASE TAKE A MINUTE TO CAREFULLY FILL OUT THE APPROPRIATE INFORMATION. THE INFORMATION ALLOWS US TO GET TO KNOW YOU, YOUR HEALTH AND PAST MEDICAL HISTORY BETTER. THIS WILL ALLOW US TO MAKE THE BEST DECISIONS FOR YOU!

HEIGHT: _____ **WEIGHT:** _____

ALLERGIES OR INTOLERANCES
(Include medications, herbals, and topical applications)
_____
_____
_____

CURRENT MEDICATIONS (include over the counter, Aspirin/Tylenol, birth control, diet, vitamins, or herbal)
_____
_____
_____
_____

MAJOR MEDICAL CONDITIONS, INJURIES, OR HOSPITALIZATIONS (include dates)
_____
_____
_____

PREVIOUS SURGERIES OR PROCEDURES (include all surgeries and procedures including medical, cosmetic or skin procedures, medical, plastic or reconstructive surgeries)
_____
_____
_____

MENTAL HEALTH CONCERNS OR TREATMENTS?
_____
_____
_____

LIST CURRENT SKIN CARE PRODUCTS (if any)
_____
_____
_____

REVIEW OF SYSTEMS

CONSTITUTIONAL
- ☐ Fever
- ☐ Unexplained weight loss
- ☐ Night sweats
- ☐ Chronic fatigue
- ☐ Malaise or lethargy

SKIN
- ☐ Pruritus
- ☐ Rashes
- ☐ Eczema
- ☐ Nodules
- ☐ Tumors
- ☐ Scars-raised or keloid

EYES & ENT
- ☐ Visual changes
- ☐ Double vision
- ☐ Blind spots
- ☐ Eye pain
- ☐ Eye discharge
- ☐ Nasal allergy symptoms
- ☐ Nasal drainage
- ☐ Difficult nasal breathing
- ☐ Difficulty hearing
- ☐ Difficulty swallowing

LUNGS
- ☐ Cough
- ☐ Sputum
- ☐ Wheeze
- ☐ Bleeding from coughing
- ☐ Bronchitis or emphysema
- ☐ Asthma
- ☐ Shortness of breath
- ☐ Other _____

URINARY
- ☐ Incontinence
- ☐ Pain on urination
- ☐ Bleeding on urination
- ☐ Urinating too much

MUSCULOSKELETAL
- ☐ Joint/muscle pain
- ☐ Joint/muscle stiffness
- ☐ Joint swelling
- ☐ Neck pain/stiffness

NEUROLOGICAL
- ☐ Headache
- ☐ Seizures
- ☐ Numbness/weakness

HEMATOLOGIC
- ☐ Anemia
- ☐ Prolonged or excessive bleeding
- ☐ Bleed easily
- ☐ Bruise easily

GENITOURINARY
- ☐ Have you had urinary infections YES/NO
- ☐ Do you have regular periods YES/NO
- ☐ Number of pregnancies _____
- ☐ Number of deliveriess

Which services are you inquiring?

☐ Acne treatment/Surgery ☐ Active/Deep FX ☐ Botox ☐ Chemical Peel ☐ Dermal Fillers ☐ Dermaplaning ☐ Extractions ☐ Facial Plastic and Reconstructive Surgery ☐ Fotofacials ☐ Hair Transplants ☐ Laser Hair Removal ☐ Microdermabrasion ☐Skincare Treatments/Products ☐ Tattoo Removal ☐Vein Treatment

What are your expectations of the above treatment or procedure?

MEDICAL & SURGICAL HISTORY (PART 2 of 2)

MEDICAL HISTORY

SKIN & HAIR

☐ Accutane use
☐ Allergic dermatitis or eczema
☐ Alopecia (hair loss)
☐ Atypical or dysplastic moles
☐ Cystic acne
☐ Fever blisters or cold sores
☐ Herpes Simplex
☐ Melanoma
☐ Melasma
☐ Psoriasis
☐ Rosacea
☐ Seborrhoeic dermatitis
☐ Shingles
☐ Skin cancer
☐ Other _____

EYE & ENT

☐ Sinus infections
☐ Nose bleeds
☐ Sleep apnea
☐ CPAP use
☐ Eye allergy symptoms
☐ Dry eye symptoms
☐ Glaucoma
☐ Cataract
☐ Corrective- glasses/contact
☐ Correcting surgery
☐ Problems w/teeth or gums
☐ Other _____

COSMETIC HISTORY

☐ Botox/fillers use
☐ Chemical peel
☐ Microdermabrasion
☐ Laser skin treatment
☐ Other _____

GASTROINTESTINAL

☐ Ulcers
☐ Hepatitis
☐ Inflammatory bowel disorder
☐ Diverticulosis
☐ Frequent heartburn or reflux
☐ Abdominal pain
☐ Nausea/vomiting
☐ Diarrhea/constipation
☐ Other _____

NEUROLOGIC & MUSCULOSKELETAL

☐ Seizure disorder
☐ Nerve disorder
☐ Chronic pain disorder
☐ Spine/disc disorder
☐ Artificial joints
☐ Insomnia
☐ Other _____

CARDIOVASCULAR

☐ Heart attack
☐ Stroke
☐ High blood pressure
☐ Deep vein clots
☐ Irregular heartbeat
☐ Pacemaker
☐ Cardiac stents
☐ Artificial valves
☐ Mitral valve prolapse
☐ Heart valve replacement
☐ Fainting spells
☐ Chest pain
☐ Shortness of breath
☐ Exercise intolerance
☐ Lower leg swelling
☐ Palpitations

SYSTEMIC

☐ Diabetes
☐ History of anemia
☐ Thyroid disorder
☐ Autoimmune disorder
☐ HIV/AIDS or exposure
☐ Tuberculosis
☐ Cancer (other than skin)
☐ Current/upcoming pregnancy
☐ Poor healing or scarring
☐ Increased bleeding or bruising
☐ Bad reaction to anesthetics
☐ Low pain tolerance
☐ Significant weight fluctuation
☐ Liver Disease
☐ Other _____

FAMILY HISTORY

☐ Alcoholism
☐ Allergies
☐ Bleeding tendencies
☐ Cancer
☐ Congenital defects
☐ Diabetes
☐ Epilepsy
☐ Heart attacks
☐ High blood pressure
☐ Stomach problems
☐ Strokes
☐ Suicide
☐ Other

KIDNEYS

☐ Prostate problems
☐ Kidney failure or dialysis
☐ Other _____

SOCIAL HISTORY (indicate if PAST or PRESENT)

TOBACCO USE – YES / NO = CURRENT/PAST

_____Packs per day for _____ years; quit_____

ALCOHOL USE – YES / NO

_____Drinks per day for _____ years; quit/current

ILLICIT DRUG USE – YES / NO

What substance? _____

SUBSTANCE DEPENDENCY – YES / NO

What substance? _____

RECENT TREATMENTS

( ) Waxed ( ) Electrolysis ( ) Chemical Peel
Laser ( )
( ) Sunburned

ARE YOU CURRENTLY USING

( ) Accutane ( ) RetinA ( ) Hormonal Therapy

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