HUNTINGTON WOMEN´S HEALTH

Aesthetics-Cosmetic Surgery-Gynecology

Why Wait Any Longer… Restore Your Youth Today!

Patient's Last Name_____

First Name_____ S.S#_____

Address_____City/state_____

Zip_____

Home Number (_____) _____-_____Cell # **(____)_____-_____**

D.O.B ____/____/____ Age____

Pharmacy #: (____)_____-_____ **Email:**_____

If patient is a minor, name of parent_____

Patient's employer's name_____ Occupation_____

Work number (____)____-_____

Work address_____

City/state_____Zip_____

How did you hear about us?

Friend_____

Our patient_____

Magazine:_____

Internet:_____

Website:_____

Television:_____

Physician referral:_____

Other (Please specify):_____

PLEASE READ: ALL CHARGES ARE DUE AT THE TIME OF SERVICE. IF SURGERY IS INDICATED, THE PATIENT IS RESPONSIBLE FOR FURNISHING INSURANCE CLAIM FORMS TO THE OFFICE PRIOR TO SURGERY. ALL PROFESSIONAL SERVICES RENDERED ARE CHARGED TO PATIENT. NECESSARY FORMS WILL BE COMPLETED TO EXPEDITE INSURANCE CARRIER PAYMENTS. THE PATIENT IS RESPONSIBLE FOR ALL FEES, REGARDLESS OF INSRUANCE COVERAGE. IT IS CUSTOMARY TO PAY FOR SERVICES WHEN RENDERED UNLESS OTHER ARRANGEMENTS HAVE BEEN MADE IN ADVANCE.

SIGNATURE_____

☐ I consent to medical test and procedures in the office as may be deemed necessary for my care.
☐ I consent to receiving information from your practice via Email ☐ Text ☐ Phone ☐ Mail ☐
☐Please DO NOT contact me with any information about your practice
Follow my HIPPA release form for health related correspondence

Signature of patient _____ Date_____/_____/_____

Parent/Guardian Info(To be completed if the patient is a minor or if a guardian of attorney over the patient's medical care)

Name(last, first ,middle):_____
Home Phone:_____Cell Phone:_____
Work Phone:_____
Email address:_____

Name: _____Date:_____

(Nombre) (Fecha)

Age: _____ Height: _____ Weight: _____

(Edad) (Altura) (Peso)

List allergies to ANY medications: _____

(Las alergias a algún medicamento)

_____

List the medication you take: _____

(Lista de las medicinas que usted toma)

Health History

Date of last physical exam:_____ By Dr:_____

Date of last Flu Immunization?_____

Are you? Pregnant_____ Nursing_____

First day of your last menstrual period?_____

Surgeries/Dates:_____

DO YOU HAVE ANY OF THE FOLLOWING MEDICAL CONDITIONS? (Check one)

¿TIENE USTED ALGUNA DE LAS SIGUIENTES CONDICIONES MÉDICAS? (Marque uno)

☐ ☐
YES NO 1. Heart disease (angina, heart attack, mitral prolapsed, skipping, etc.)

☐ ☐
SI NO 1. Enfermedades del corazón (angina de pecho, ataque cardíaco, prolapso mitral, saltar, etc.)

☐ ☐
YES NO 2. High blood pressure

☐ ☐
SI NO 2. Hipertensión

☐ ☐
YES NO 3. Lung disease (asthma, bronchitis, emphysema, sleep apnea, etc.)

☐ ☐
SI NO 3. Enfermedad pulmonar (asma, bronquitis, enfisema, apnea del sueño, etc.)

☐ ☐
YES NO 4. Liver disease (jaundice, hepatitis, etc.)

☐ ☐
SI NO 4. Enfermedad del hígado (ictericia, hepatitis, etc.)

☐ ☐
YES NO 5. Kidney disease

☐ ☐
SI NO 5. Enfermedad renal

☐ ☐
YES NO 6. Diabetes

☐ ☐
SI NO 6. Diabetes

☐ ☐
YES NO 7. Thyroid disease

☐ ☐
SI NO 7. Enfermedad del tiroides

☐ ☐
YES NO 8. Blood Disease (anemia, sickle cell, clotting disorder, excessive bleeding etc.)

☐ ☐
SI NO 8.Enfermedad de la sangre (anemia falciforme, trastornos de la coagulación, etc.)

☐ ☐
YES NO 9. Neurological Disease (stroke, TIA, epilepsy, herniated disk, etc.)

☐ ☐
SI NO 9. Enfermedades Neurológicas (TIA avivar, epilepsia, hernia de disco, etc.)

☐ ☐
YES NO 10. Gastrointestinal Disease (reflux, ulcers, colitis, etc)

☐ ☐
SI NO 10. Enfermedades gastrointestinales (reflujo, úlceras, colitis, etc.)

☐ ☐
YES NO 11. Mental Health Issues (anxiety, depression, substance abuse etc.)

☐ ☐
SI NO 11. Problemas de salud mental (ansiedad, depresión, abuso de sustancias, etc.)

☐ ☐
YES NO 12. Auto Immune disorders known to cause sensitivity to light (Lupus)

☐ ☐
SI NO 12. Trastornos auto inmunes causados por sensibilidad a la luz (Lupus)

☐ ☐
YES NO 13. History of cold sores or fever blisters, herpes

☐ ☐
SI NO 13. Historia del herpes labial o herpes febril, herpes

☐ ☐
YES NO 14.Neuromuscular disorders

☐ ☐
SI NO 14. Trastornos Neuromusculares

☐ ☐
YES NO 15. Have you had any sun exposure, tanning bed, tanning cream or spray tanning in the last 4 weeks?

☐ ☐
SI NO 15. ¿Ha tenido alguna exposición al sol, cabina de bronceado, crema bronceadora o spray de bronceado en las últimas 4 semanas?

☐ ☐
YES NO 16. Have you been on Accutane within the last 6 months?

☐ ☐
SI NO 16. ¿Has estado bajo tratamiento de Accutane en los últimos 6 meses?

☐ ☐
YES NO 17.Have you ever recieved gold therapy?

☐ ☐
SI NO 17. ¿Alguna vez ha recibido tratamiento con oro?

☐ ☐
YES NO 18. Do you have a history of healing problems or a history of keloid formation?

☐ ☐
SI NO 18. ¿Usted tiene un historial de problemas o antecedentes de formación de queloides?

☐ ☐
YES NO 19. Are you recieving immunosuppressant therapy?

☐ ☐
SI NO 19. ¿Está recibiendo tratamiento inmunosupresor?

☐ ☐
YES NO 20. Do you have a history of skin cáncer or suspicious lesions?

☐ ☐
SI NO 20. ¿Usted tiene un historial de cáncer de piel o lesiones sospechosas?

☐ ☐
YES NO 21. Do you have any history of seizures triggered by light?

☐ ☐
SI NO 21. ¿Tiene usted alguna historia de convulsiones provocadas por la luz?

☐ ☐
YES NO 22. Have you taken antibiotics within the last 2 months?

☐ ☐
SI NO 22. ¿Ha tomado antibióticos en los últimos 2 meses?

☐ ☐
YES NO 23. Other medical problems? _____

☐ ☐
SI NO 23 .Otros problemas médicos?_____

PLEASE CHECK THE ANSWER TO THE FOLLOWING QUESTIONS:

POR FAVOR MARQUE LAS RESPUESTAS A LAS SIGUIENTES

PREGUNTAS:

☐ ☐
YES NO 1. Do you smoke? If yes how much? _____

☐ ☐
SI NO 1.¿Fuma usted? Si es así ¿cuánto? _____

☐ ☐
YES NO 2. Have you had anything to eat or drink today?

☐ ☐
SI NO 2.Ha tenido algo de comer o beber hoy?

YES NO 3. Do you drink alcohol? If yes circle social? Weekends? Daily?

SI NO 3. Bebes alcohol? Si es así, marce: Social? Fines de Semana? Todos los días?

YES NO 4. Do you wear dentures?

SI NO 4. usa dentadura postiza?

YES NO 5. Are your front teeth capped or bonded?

SI NO 5. Son sus dientes tapados o en condiciones de servidumbre?

YES NO 6. Do you wear contact lenses?

SI NO 6. Usted usa lentes de contacto?

YES NO 7. Have you had problems with wit anesthesia before?

SI NO 7. Ha tenido problemas con la anestesia antes?

YES NO 8. Has any member in your family had problem with anesthesia?

SI NO 8.Algún miembro de su familia ha tenido problemas con la anestesia?

YES NO 9. Are you allergic to latex?

SI NO 9.Es usted alérgico al látex?

YES NO 10. Do you have any prosthetics/devices in your body?

SI NO 10. Tiene alguna prótesis / dispositivos en su cuerpo?

YES NO 11. Are you pregnant?

SI NO 11. Está embarazada?

YES NO 12. Do you take any herbal supplements? If you answered yes please list them?_____

_____

SI NO 12.Toma suplementos herbales? Si su respuesta es sí por favor escriba._____

By printing your name below, you are agreeing to electronically submit this document.

Patient signature/ firma del paciente: _____

Nurse's Signature _____