HUNTINGTON WOMEN'S HEALTH

Aesthetics-Cosmetic Surgery-Gynecology

Why Wait Any Longer... Restore Your Youth Today!

Patient Health History Form

Name _____ Date of Birth_____

Address _____ City/State/Zip _____

Home Phone _____ Work/Mobile Phone _____

Email _____ How did you hear about us? _____

What is your skin care goal? _____

Emergency Contact Name and Number _____

Which of the following best describe your skin type?

I	Always burns, never tans
II	Always burns, sometimes tans
III	Sometimes burns, always tans
IV	Rarely burns, always tans
V	Brown, moderately pigmented skin
VI	Extremely dark skin

Do you have any health problems of medical conditions? Please list:

_____

If you are presently under the care of a physician, please list for what illness or purpose.

_____

Please list ALL allergies you my have (medicines, food, pollen, etc.) and briefly describe your reaction (i.e. rash, hives, shortness of breath, etc.). If no allergies, please write NONE.

_____

Are you currently using or have you used any of the following medications within the last 6 months?

☐ Accutane ☐ Retin-A ☐ Tretinoin ☐ Isotreintoin
☐ Tetracycline ☐ Griseofulvin ☐ Ciprofloxacin ☐ Naproxen ☐ Amiodarone ☐ Thiazides

Please list any medications, including prescription and over-the counter medicines, topical creams, facial skin care product and medicinal herbs you take:

_____

_____

When you look in the mirror, what bothers you the most?

_____

At home skin care:

_____

Huntington Women's Health

Aesthetics & Cosmetic Surgery

Interest Questionnaire

Name:_____

Email:_____

Please select which of the following you have an interest in to speak with one of our employees specializing in that area:

☐ Botox/Dysport (crow's feet, forehead, between eyebrows, around mouth)

☐ Fillers (for lips, cheeks, and smile lines)

☐ Cosmetic Surgery (breast augmentation, breast reduction, breast lift, tummy tuck, liposuction, blepharoplasty [eyelids],

☐ Laser Hair Removal (lip, underarms, bikini, legs, arms, etc)

☐ Laser vein/sclerotherapy (face and legs)

☐ Laser Facial (for dark spots, uneven skin tone)

☐ Chemical Peels

☐ Permanent makeup (eyebrows, eyeliner, lip liner)

☐ SkinMedica Product line (growth factors, retinol, dark spots, sunscreen, etc)

☐ Kybella (destroys double chin fat cells)

☐ Microneedling (acne, scars, stretch marks, anti-aging, hyperpigmentation, hair growth)

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Please check the following:	Complications from any laser or light treatments?	☐ NO ☐ YES
	Complications from any cosmetic procedures?	☐ NO ☐ YES
	Form thick or raised scars from cuts or burns?	☐ NO ☐ YES
	Hyperpigmentation (darkening of the skin)?	☐ NO ☐ YES
	Hypopigmentation (lightening of the skin)?	☐ NO ☐ YES
	Recent use of self tanning lotion, tanning or sun exposure?	☐ NO ☐ YES
	Any active infection?	☐ NO ☐ YES
	Are you pregnant?	☐ NO ☐ YES
	Any major illness or hospitalization within the last 5 years?	☐ NO ☐ YES
	Any alternative medical procedures?	☐ NO ☐ YES

I certify that the preceding medical, personal and skin history statements are true and correct. I am aware that it is my responsibility to inform the staff members of my current medical or health conditions and to update this history. A current medical history is essential for the caregiver to execute appropriate treatment procedure.

Signature _____ Date: _____

PLEASE READ: ALL CHARGES ARE DUE AT THE TIME OF SERVICE. IF SURGERY IS INDICATED, THE PATIENT IS RESPONSIBKE 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 □ E-Mail □ Text □ Mail □ Phone

☐ 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):_____
HomePhone:_____CellPhone:_____
Work Phone:_____
Email address:_____

How did you hear about us?

□Friend_____□Our patient:_____
□Magazine:_____□Internet:_____
□Website:_____
□Television:_____
□Physician referral:_____
□Other (Please specify):_____