

INTAKE INFORMATION

Patient Name _____ Age: _____ Date: _____

Reason for today's visit? _____

Where is the problem located? _____ When did it start? _____

What treatments have you tried for this problem? _____

Please list all the prescription and non-prescription medications that you are currently taking:

Do you have any allergies to medications? If so, please list each medication?

PAST MEDICAL HISTORY:

Have you ever been diagnosed with any medical conditions? If so, please list each. If none, write "none".

PAST SURGICAL HISTORY:

Have you ever any surgical procedures? If so, please list each. If none, write "none".

FAMILY HISTORY:

Are there any diseases that run in your family? _____

WOMEN ONLY: (if you answer Yes, please notify Dr. B and staff)

Are you pregnant? Yes No Are you trying to conceive? Yes No Are you breast-feeding? Yes No

REVIEW OF SYSTEMS:

Are you currently having trouble with any of the following? If yes, please describe below. If no, check here: None

- Eyes Yes _____
- Ears/ Nose/ Throat/ Mouth Yes _____
- Heart Yes _____
- Lungs Yes _____
- Stomach/ Bowel Yes _____
- Kidneys Yes _____
- Arthritis/ Muscles/ Joints Yes _____
- Headaches/ Seizures Yes _____
- Psychological disorder Yes _____
- Endocrine/ Hormonal Yes _____
- Fever/ Chills Yes _____

COSMETIC PROCEDURES:

We offer a full range of cosmetic procedures that are NOT covered by insurance. Please check any of the boxes below if you are interested in obtaining more information:

- Botox / Dysport (wrinkles, frown lines, crow's feet)
- Restylane / Juvederm (laugh lines, fuller cheeks)
- Fuller lips
- Under eye circles
- Age spots on face and hands
- Chemical peels for acne, anti-aging, or melasma
- Acne scar treatments
- Skin tag removal
- Ear lobe repair
- Anti-aging skin care products
- Sclerotherapy for leg veins