Columbus Medical Aesthetics

MEDICAL REGISTRATION FORM

Today's Date:	PRIMARY CARE PHYSICIAN:

BASIC MEDICAL INFORMATION

Patient's last name: First:	Date of Birth:	Marital status:

Do you have a pacemaker, defibrillator or any implanted medical plates? ○ Yes ○ No	Do you have any drug, food or environmental allergies? (please list with type of reaction)	Are you currently pregnant, lactating or trying to become pregnant?	Please list all current daily medications (prescribed/homeopathic):	Sex: ○ M ○ F

Please list all surgeries:

Preferred Pharmacy Name:	Pharmacy Address:	Pharmacy Phone no.:
List all Major Medical Conditions:	Circle all that apply: keloids scars, acne, rosacea, eczema, cold sores, fever blisters, skin cancer, pigment issues (hyper or hypo), MRSA, easily bruised, psoriasis	Are you currently taking anything that may affect your ability to heal? If so, please list the medication:

I currently have a skin care regimen at home: ○ YES ○ NO

If yes, please list your protocol:

ACTIVITY INFORMATION

Please answer all questions

How easily do you tan and how often are you in the sun/tanning bed:	Do you wear sunscreen on a daily basis, if so, what SPF?:	Have you ever had any aesthetic procedures done; if yes, please list:	What major changes would you like to see in your skin (what are your goals):
Do you smoke?	○ Yes ○ No	Do you consume alcohol regularly?	○ Yes ○ No
Occupation:	Employer:	Employer address:	Employer phone no.:

Please describe your sleeping habits (number of hours a night):

How much water do you drink a day:	How many meals do you have a day:	Please list any special diets you follow:

Do you exercise regularly, if so, how often:

Please list any other information you would like your provider to know:

Who is your dermatologist: Date of your last visit:

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Phone no.:

Signature: