

New Patient Information

Name: _____ Birth Date: ____ / ____ / ____ Age: _____

Address: _____ Sex: _____
M / F

City: _____ State: _____ Zip Code: _____

Home: (____) Work: (____) Cell: (____)

E-mail: _____

Emergency Contact: _____ Telephone: (____)

Allergies: _____

How did you hear about THE CENTER FOR WOMEN'S HEALTH?

Please put a check mark next to the procedures about which you would like to receive more information:

Acne Treatment Botox to Flatten and Prevent Wrinkles Enhanced Skin Rejuvenation Collagen Augmentation Wrinkles Skin Toning or Pore Size Reduction Facial Redness Brown Spots Sun Damage Broken Capillaries Spider Veins/Leg Veins Hair Removal Shaving bumps/ingrown hair

Please put a check mark next to a past or current medical condition:

Medical History: Lupus or other auto-immune deficiency (A) Pregnant (A) Bleeding abnormalities (A) Treatment with Accutane® in the last six months (A) Keloid or very thick scarring (A) Psoriasis or Vitiligo (A) Pulmonary embolism/blood clot (V) Leg ulcer or Phlebitis (V) Blood thinning medication (V) Rheumatoid Arthritis "Gold" Therapy (A) Cystic Acne (P) Herpes simplex or fever blisters (A) Diabetes (A) Epilepsy (A) Scars that turn white or brown (A) Dark spots after pregnancy, skin injury (A) HIV (A) Hepatitis (A) Waxing/Plucking/Electrolysis within last four weeks (HR) Hirsutism (HR) Transplant Anti-Rejection Drugs (HR) Chemical Peels, Dermabrasion, Laser Resurfacing or Face Lift (A)

Please list any medications or herbal supplements that you are currently taking:

Patient Signature

Date