Transformations Spa MD PLLC

Date_____

Patient Intake Form

Patient Name_____Age_____Date of Birth_____

Address_____

City_____State_____Zip Code_____

Phone (home)_____Phone (work)_____

Phone (cell)_____Email_____

Referring Physician:_____

Primary Care Physician:_____

How did you hear about us?_____

Which body area/areas or condition would you like treated**?**_____

(For women) are you or could you be pregnant?	**Yes / No_____**
(For women) are your menstrual periods normal?	Yes / No_____
Do you have a history of Herpes I or II in the area to be treated?	Yes / No_____
Do you have a history of keloid scarring?	Yes / No_____
Have you taken Accutane or anticoagulants in the last 6 months?	Yes / No_____
Do you have any permanent make-up, implants or tattoos?	Yes / No_____
Have you had any unprotected sun exposure, used tanning creams or tanning beds on the last 4-6 weeks?	Yes / No_____

Hair removal in the last 6 weeks (circle applicable) – shaving – tweezing – waxing – depilatories

Current skin care line/product

_____

MEDICATION HISTORY

Please list all current medications/herbs and dosages_____

ALLERGIES (check one)

_____No known allergies

_____Allergies and reactions to medication, food, latex, other:_____

PAST SURGERIES OR HOSPITALIZATIONS: Please list with date:

_____

_____

PAST AESTHETIC/MEDICAL COMESTIC PROCEDURES AND DATES:

_____

_____

PAST MEDICAL HISTORY (other current health problems)

_____

_____

ARE YOU UNDER A DOCOTORS CARE? YES / NO

Describe_____

_____

Do you now have or have you ever had:

Neurologic (seizures, headaches, weakness, paralysis) problems	Yes / No_____
Head/Ear/Eye/Nose/Throat Problems	Yes / No_____
Lung Problems	Yes / No_____
Breast Problems	Yes / No_____
Kidney or Bladder Disease	Yes / No_____
Liver or Kidney Problems (stones, Nephritis)	Yes / No_____
Hematological (bleeding, anemia) Problems	Yes / No_____
Diabetes (insulin dependent/oral medication)	Yes / No_____
Musculoskeletal (bones, joints, muscles) Problems	Yes / No_____
Circulation problems (varicose veins, thrombosis)	Yes / No_____
Cancer (Type) :_____	Yes / No_____
High Blood Pressure	Yes / No_____

Other_____

FAMILY HISTORY

Check illnesses which have occurred in any blood relative and write relationship to you:

☐ Cancer_____

☐ Bleeding Disorder_____

☐ Heart Disease_____

☐ Diabetes_____

☐ Other_____

SOCIAL HISTORY

Occupation_____

Tobacco use: Yes / No Daily Amount_____ Number of Years_____

Caffeine use Yes / No Daily Amount_____ Number of Years_____

_____ _____/_____/_____

Signature Date