New Patient History Form

ALL ABOUT YOU MEDICAL SPA

Date____________ (for Dr. Gould/Skin type______)

Name:_____________________________ Age________ Gender______

Birthdate:___________________ Weight:________________ BMI:______

Height______________

Phone: H______________ W_____________ C________________

Cell phone carrier(for confirmations)__________

Email____________________

Address:_______________________________________

____

Best way to contact patient_______________________

Emergency Contact______________________________________

Relationship____________________ permission to contact in emergency_______(initial)

What would you like to discuss today?

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Past Medical/Surgical

History____

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Allergies____

Medications____

Vitamins____

Are you a smoker?______Last menstrual period__________ Menopause: Y N

Are you currently optimizing your hormones?_____How?_______________________________

List any pertinent medical issues you may have___________________________________

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How do you rate your overall health?__________________________________

Please describe your diet and exercise routine____________________________________

____

Previous Aesthetic Treatments____

____

List any concerns you may have____

____

How did you find out about us?____