NORTH SHORE AESTHETICS

(847) 393-4770

Patient Information as of _____ (enter today's date)
(Please Print Legibly & Fill In or Correct All Fields)

Patient's Name _____
Last First Middle

Address _____
Street & Apt # City State Zip

Home Phone _____ Cell Phone _____ Other Phone _____

Any restrictions for contacting you? ❒ No ❒ Yes E-mail _____

Contact Restrictions: _____ Drivers License # (include State) _____

Age _____ Birthdate ___/___/___ SS# ___-___-___ Sex ❒ Female ❒ Male

Marital Status ❒ Single ❒ Married to: _____ Race: Religion: _____

Patient's Employer _____ Occupation _____

Work Phone _____ Ext: _____ Is it okay to call you at work? ❒ Yes ❒ No

Address _____
Street & Suite # City State Zip

Emergency Contact _____ Relationship to Patient _____

Home Phone _____ Work Phone _____ Other Phone _____

Address _____
Street & Apt # City State Zip

Primary Care Physician
Name_____

Primary Health Insurance Company _____

Policy # _____ Group # _____ Ins. Phone _____

Referral Required? ❒ No ❒ Yes Copay? ❒ No ❒ Yes, $ _____

Insured: Name _____ DOB _____ Employer _____

Secondary Health Insurance Company _____

Policy # _____ Group # _____ Ins. Phone _____

Referral Required? ❒ No ❒ Yes Copay? ❒ No ❒ Yes, $ _____

Insured: Name _____ DOB _____ Employer _____

How did you hear about us?_____

Detailed reason for office visit_____

_____

Were you seen by another Doctor for this condition? If you were, by whom and when?_____

_____

Please indicate if you are being treated for any of the following conditions:

High blood pressure:_____ Diabetes_____Heart Condition_____Asthma_____Cancer_____

Mitral Valve Prolapse_____HIV positive_____Other(explain)_____

Are you right or left handed? _____

_____

List the prescription and over the counter medications you are presently taking:

DRUG STRENGTH TIMES PER DAY SPECIAL INSTRUCTION

1._____

2._____

3._____

4._____

5._____

6._____

FOR ACCIDENTS, PLEASE COMPLETE:

Type of Accident: Automobile Employment Other (please explain):_____

_____

_____

For automobile only: with whom, if a passenger:_____

Date and time incident occurred:_____

Give specific details of accident, including where it occurred:_____

_____

If you were treated in the ER, when and where:_____

Attending Doctors:_____

Transported by ambulance or automobile:_____

Were you admitted?_____

Date of discharge:_____

Name: _____

List Drug Allergies

Allergy	Reaction

List Current Vitamins or Supplements

Name	Dosage

Past Medical History

- ○ Denies Past Medical History
- ○ Abnormal Bleeding
- ○ Asthma
- ○ Breast Cancer
- ○ Cancer
- ○ Chest Pain/Tightness
- ○ Diabetes
- ○ Eczema
- ○ Heart Disease
- ○ Heart Murmur
- ○ Hepatitis

Past Medical History continued

- ○ High Blood Pressure
- ○ Hives
- ○ Kidney Stones
- ○ Skin Cancer
- ○ Melanoma
- ○ Basal Cell Carcinoma
- ○ Squamous Cell Carcinoma
- ○ Actinic Keratosis
- ○ Skin Disease
- ○ Stroke
- ○ Thyroid Disorder
- ○ Ulcers
- ○ X-Ray Therapy
- ○ Other _____

Height_____ Weight_____

Anesthesia History

- ○ No Past Problems
- ○ Never had Anesthesia
- ○ Nausea/Vomiting
- ○ Allergic Reaction
- ○ Difficult intubation/extubation
- ○ Malignant Hyperthermia
- ○ Difficulty Waking Up
- ○ Post-Op N/V
- ○ Nausea
- ○ Vomiting
- ○ Local Anesthetic Complication
- ○ Sensitivity to Anesthesia Agent

Past Surgeries

Procedure Date

_____

_____

_____

_____

Family History

- ○None
- ○Abnormal Bleeding/Abnormal Clotting
- ○Autoimmune Disorders
- ○Breast Cancer
- ○Cancer
- ○Cleft Lip/Cleft Palate
- ○Diabetes
- ○Drug Allergies
- ○Endocrine Disease
- ○Hearing Loss
- ○Heart Disease
- ○High Blood Pressure
- ○Hemophilia
- ○Kidney Disease
- ○Liver Disease
- ○Lung Disease
- ○Malignant Hyperthermia
- ○Skin Cancer

Family History Continued

- ○Skin Disease
- ○Substance Abuse
- ○Von Willerbrand
- ○Other _____

Social History

○Denies Alcohol Use	○Denies Smoking
○Alcohol Use Daily	○Smokes Daily
○Alcohol Use Socially	○Smokes Occasionally
○_____ Drinks per Week	○_____ Packs per Day
○Denies Illegal Drug Use	○Admits Illegal Drug Use
○Denies High Risk Factors	○Admits High Risk Factors
○Denies STD History	○Admits STD History

Ability to Heal

Does your skin appear fragile or burns easily? ○Yes ○No

Do you form thick/raised scarring from cuts/burns? ○Yes ○No

Do you wax or use depilatories on your face? ○Yes ○No

Do you ever get cold sores? ○Yes ○No

Female Questions

Do you have regular periods? ○Yes ○No

Are you going through Menopause? ○Yes ○No

Are you pregnant or lactating? ○Yes ○No

With pregnancy, did you have hyperpigmentation/masking? ○Yes ○No