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Patient Information Form

Name: ______________________________ Birth Date: _________ Age: _____ Sex: M F
Address: ____
City: _________________________________ State: _______________ Zip: ______________
Primary Phone: _________________________ Cell Phone: ____________________________
Email: ____

Reason for visit today: ____
How did you learn about us? ____

In Case of Emergency:
Name: __________________________ Relationship: _____________ Phone: _______________
Family Physician: ____

Medical History Form

Height: _______ Weight:_______ **BMI:**_______________

1. Are you in good health at the present time to the best of your knowledge? Yes No
2. Are you under a doctor's care at the present time? Yes No If yes, for what?

____

3. Are you taking any medications or supplements at the present time? Yes No

____

4. Any allergies to any medications? Yes No _______________________________________

____

5. Past Medical History: (circle all that apply)

Lupus / Auto Immune Deficiency		Pregnancy	Psoriasis / Vitiligo	Cystic Acne	Hirsutism
Pulmonary Embolism / Blood Clot		Hepatitis	Leg Ulcer / Phlebitis	Herpes Simplex / Fever Blisters	
Keloid / Thick Scarring		Dark Spots	Waxing/ Plucking Within 4 weeks		
Chemical Peels	Dermabrasion	Laser Surfacing	Face Lift		
Ulcers	Gallstones	Heart Disease	Liver Disease	Ulcers	Thyroid Disease
Bleeding Disorder	Cancer	Heart Disorder	Blood Transfusion	Drug Abuse	Eating Disorder
Alcohol Abuse	Other : ______________________				

Past Surgeries / Year : ____

6. History of : High Blood Pressure? Yes No Diabetes? Yes No (If yes, at what age: ____)
Heart Attack / Chest Pain? Yes No Swelling Feet? Yes No
Frequent Headaches or Migraines? Yes No If so, Medications for Headaches: ______________

Please check all the procedures about which you would like to receive more information.

___ **Acne Treatment**	___ **Brown Spots**	___ **Sun Damage**	___ **Age Spots**
___ **Skin Rejuvenation**	___ **Broken Capillaries**	___ **Fillers**	___ **Botox**
___ **Wrinkle Correction**	___ **Skin Toning**	___ **Facial Redness**	___ **Shaving Bumps**
___ **Hair Removal**	___ **Obagi Skincare**	___ **Latisse**	___ **Fat Removal**
___ **Skin Tightening**	___ **Weight Loss**	___ **Vitamins & Minerals**	

Financial Policy:
Thank you for selecting Dr. Macedonia for your health care needs. We are honored to be of service to you. This is to inform you of our billing requirements and our financial policy. Please be advised that payment for all services will be due at the time services are rendered. Smartlipo payment due upon scheduling. I have read and understand all of the above and have agreed to these statements.

Patient's Signature: ____ Date: ______________________