



Patient Information & History Form

A. Patient Information

Date: _____

Name _____
Last Name First Name Middle Initial

Address _____

City _____ State : _____ Zip _____

Home Phone (____) _____ Cell Phone: (____) _____

Work Phone: (____) _____ Sex: (check one) Male Female

Age _____ Birth date _____ Married Single Widowed Minor
 Separated Divorced Partnered

Email Address: _____

Patient Employer/School: _____ Occupation: _____

HOW DID YOU HEAR ABOUT US? (Please Check Box)

- Dallas Voice Derm Aesthetics & Laser Center Hair Removal Journal
 Radio Derma Network American Health & Beauty
 Patient: _____ Other: _____
 Googled: (What did you google ?) _____
(What Web Site did you find?) _____

Do you have a FaceBook page? Y or N *May we send you an invitation to join our Fan Page?* Y or N

In case of an emergency who should be notified? _____ (Relation): _____

Phone (____) _____

Primary Care Physician: _____ Phone: (____) _____

E-mail / Postal Mail Authorization:

I hereby authorize the staff of Anthony Caglia, M.D. to communicate with me via e-mail, regular mail, or by phone at the listed address and numbers provided for the purpose of office related communications, and new or existing office updates and specials.

B. Payment

I understand that cosmetic procedures are not covered by insurance and that I am responsible for payment in full at the time services are rendered.

Patient Initials

Date

C. Confidential Medical Information and History *(Please check all that apply)*

Current weight? _____ Height? _____ Weight loss/gain within 12 mons. _____

Are you pregnant? Yes No Trying to conceive? Yes No

Date of last period: _____ Are you on Birth Control: _____

Do you smoke? Yes No How many packs per day? _____ How many Years : _____

Do you use Alcoholic Beverages? Yes No Consumption of Alcohol on a weekly basis: _____

Do you wear contact lenses? Yes NO *******(remove contacts** if eyes are sensitive or having Microdermabrasion or Chemical Peel) ***** We are not responsible for loss of contact lenses here at our office during treatment. *****

History of: (CHECK ALL THAT APPLY) * **PLEASE CIRCLE NO IF NONE OF THESE APPLY** NO

- | | | | |
|-------------------------------------|--------------------------|-----------------------------------|--------------------------|
| Accutane Use | <input type="checkbox"/> | Keloid Scarring | <input type="checkbox"/> |
| Anemia | <input type="checkbox"/> | Leg Pain | <input type="checkbox"/> |
| Anxiety | <input type="checkbox"/> | Leg Swelling | <input type="checkbox"/> |
| Asthma | <input type="checkbox"/> | Liver Disease | <input type="checkbox"/> |
| Arthritis | <input type="checkbox"/> | Lung Disease | <input type="checkbox"/> |
| Autoimmune Disease (Lupus,MS) | <input type="checkbox"/> | Melanoma | <input type="checkbox"/> |
| Bleeding Disorder | <input type="checkbox"/> | Menopause | <input type="checkbox"/> |
| Blood Clots | <input type="checkbox"/> | Migraine Headaches | <input type="checkbox"/> |
| Blurry Vision | <input type="checkbox"/> | Miscarriage | <input type="checkbox"/> |
| Bronchitis | <input type="checkbox"/> | Mitral Valve Prolapse | <input type="checkbox"/> |
| Bruise Easily | <input type="checkbox"/> | Nasal Allergies | <input type="checkbox"/> |
| Cancer | <input type="checkbox"/> | Neuro Muscular Disease | <input type="checkbox"/> |
| Chest Pain | <input type="checkbox"/> | Pace Maker/ Stent | <input type="checkbox"/> |
| Cirrhosis | <input type="checkbox"/> | Paralysis/ Numbness | <input type="checkbox"/> |
| Colitis | <input type="checkbox"/> | Permanent Cosmetics | <input type="checkbox"/> |
| Decreased Circulation(fingers/toes) | <input type="checkbox"/> | Psoriasis | <input type="checkbox"/> |
| Depression | <input type="checkbox"/> | Pulmonary Embolism | <input type="checkbox"/> |
| Diabetes | <input type="checkbox"/> | Reaction to Anesthesia | <input type="checkbox"/> |
| Dizziness | <input type="checkbox"/> | Restless Leg Syndrome | <input type="checkbox"/> |
| Eczema (Atopic dermatitis) | <input type="checkbox"/> | Rosacea | <input type="checkbox"/> |
| Emphysema | <input type="checkbox"/> | Seizures | <input type="checkbox"/> |
| Gall Bladder Disease | <input type="checkbox"/> | Sever Headaches | <input type="checkbox"/> |
| Glaucoma | <input type="checkbox"/> | Shortness of Breath | <input type="checkbox"/> |
| Gout | <input type="checkbox"/> | Skin Cancer- Basal, Squamous Cell | <input type="checkbox"/> |
| Hair Loss | <input type="checkbox"/> | Skin Infections | <input type="checkbox"/> |
| Hay Fever | <input type="checkbox"/> | Skin Irritations | <input type="checkbox"/> |
| Heart Disease | <input type="checkbox"/> | Skin Rashes | <input type="checkbox"/> |
| Heart Murmur Prolapse | <input type="checkbox"/> | Stomach Ulcers | <input type="checkbox"/> |
| Hepatitis A,B,C | <input type="checkbox"/> | Thrombophlebitis (clothing) | <input type="checkbox"/> |
| Herpes Cold Sores | <input type="checkbox"/> | Thyroid Disease | <input type="checkbox"/> |
| HIV/Aids | <input type="checkbox"/> | | |
| Hypertension | <input type="checkbox"/> | | |
| Insomnia | <input type="checkbox"/> | | |
| Kidney Disease | <input type="checkbox"/> | | |
| Kidney Stones/Infection | <input type="checkbox"/> | | |

Have you ever been under the care of a psychiatrist? Yes No

IF yes, please explain: _____

D. PAST SURGERY HISTORY

Have you had previous cosmetic, plastic or reconstructive surgery? Yes No

What type of surgery? _____ Date: _____

By whom? _____

Where there aspects of your surgery that did not meet your expectations? Yes No

If yes, please specify _____

Have you ever had any other type of surgery? Yes No

Type of Surgery? _____ Date: _____

Type of Surgery? _____ Date: _____

Type of Surgery? _____ Date: _____

Did you experience any complications? Yes No

If yes, please specify _____

Have you ever had local anesthesia (Novocain, Xylocaine, etc.) by a dentist or doctor? Yes No

Have you ever experienced an adverse reaction to anesthesia? Yes No

If yes, please describe the type of reaction: _____

E. ETHNICITY: This information is very important in order for your physician to serve you correctly and insure the best possible results for your skin treatment.(Please circle one)

Angelo-Saxon (Caucasian), Hispanic, Asian, African American, Indian, Middle Eastern, Other (please specify)

Do you understand that medical and surgical treatments cannot promise or guarantee a good outcome? Yes No

Do you understand that all risks and complications cannot be prevented When a surgical procedure is performed? Yes No

F. Medications

List all medications that you are now taking on a regular basis (Anticoagulants, Birth Control Pills, Hormone Replacement, Accutane, Retin-A, Renova, Sexual Performance Drugs). Include over the counter or herbal medications (Ibuprofen, Motrin, Aleve, Advil, Aspirin, Herbal Supplements, St. John's Wart, Ginkoba, etc).

Name	Strength	How Often

Allergies

List All Allergies (Medications, Antibiotics, Lidocaine, Novocain, Xylocaine, Albumin, Food, Chemicals, Latex, Eggs, Meat, Nickel, Metals)

Reason for Visit _____

Have you received treatment previously? If so, when and by whom? _____

Were you satisfied with the results? _____

G. Skin Type and Information

General Information (Please check all that apply)

Do you: Always Burn _____ Always Tan _____ Burn, then Tan _____

Skin Tone: Pale/White _____ Light _____ Medium _____ Reddish _____ Olive: _____
Dark _____

Do you consider your skin: Sensitive _____ Resilient _____ Not Sure _____

Skin Type: Normal _____ Dry _____ T-Zone/Combination _____ Oily _____
Acne _____ Breakouts _____ Acne Scarred _____

Do you use sunscreen in your skin care regimen? Yes No

Do you currently get facial waxing, laser hair removal, or depilatories (cream hair removal)? Yes No
If YES explain: _____

Have you used any products that have resulted in a bad reaction? Yes No
If so, which? _____

Current Skin Care Products 1.) _____
2.) _____
3.) _____

**I give my consent for examination, treatment, biopsy and/or excision, and the exchange of medical information for purposes of medical treatment and second opinions.
By signing this Information & History form, I acknowledge that I have been truthful and answered the following questions to the best of my ability knowing this could affect the outcome of a cosmetic or medical procedure.**

Patient Signature _____ *Date:* _____

Physician Signature _____ *Date:* _____

Reviewed By: _____ *Date:* _____

3/1/2011