



## **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 for \_\_\_yrs

Email Address: \_\_\_\_\_

Patient Employer/School: \_\_\_\_\_ Occupation: \_\_\_\_\_

How did you hear about us? (Please Check box)  Dallas Voice  Internet  Passport  
 Radio  American Health & Beauty  Hair Removal Journal  Patient \_\_\_\_\_  
 Other: \_\_\_\_\_

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.*

### **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 Date of last period: \_\_\_\_\_

Do you smoke?  Yes  No If Yes How often? \_\_\_\_\_ How many Years : \_\_\_\_\_

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)

- |                                     |                          |                              |                          |
|-------------------------------------|--------------------------|------------------------------|--------------------------|
| Anemia                              | <input type="checkbox"/> | HIV/Aids                     | <input type="checkbox"/> |
| Anxiety                             | <input type="checkbox"/> | Hypertension                 | <input type="checkbox"/> |
| Asthma                              | <input type="checkbox"/> | Hysterectomy                 | <input type="checkbox"/> |
| Arthritis                           | <input type="checkbox"/> | Insomnia                     | <input type="checkbox"/> |
| Autoimmune Disease(Lupus,MS)        | <input type="checkbox"/> | Kidney Disease               | <input type="checkbox"/> |
| Bleeding Disorder                   | <input type="checkbox"/> | Leg Pain                     | <input type="checkbox"/> |
| Blurry Vision                       | <input type="checkbox"/> | Leg Swelling                 | <input type="checkbox"/> |
| Bruise Easily                       | <input type="checkbox"/> | Liver Disease                | <input type="checkbox"/> |
| Cancer                              | <input type="checkbox"/> | Lung Disease                 | <input type="checkbox"/> |
| Chest Pain                          | <input type="checkbox"/> | Melanoma                     | <input type="checkbox"/> |
| Cosmetic Surgery (Face/Body Rejv.)  | <input type="checkbox"/> | Menopause                    | <input type="checkbox"/> |
| If Yes Date & Procedure: (list all  |                          | Migrane Headaches            | <input type="checkbox"/> |
| _____                               |                          | Miscarriage                  | <input type="checkbox"/> |
| _____                               |                          | Mitral Valve Prolapse        | <input type="checkbox"/> |
| _____                               |                          | Nasal Allergies              | <input type="checkbox"/> |
| _____                               |                          | Neuro Muscular Disease       | <input type="checkbox"/> |
| _____                               |                          | Paralysis/Numbness           | <input type="checkbox"/> |
| _____                               |                          | Permanent Cosmetics? (Where) |                          |
| Decreased Circulation(fingers/toes) | <input type="checkbox"/> | _____                        |                          |
| Depression                          | <input type="checkbox"/> | Psoriasis                    |                          |
| Diabetes                            | <input type="checkbox"/> | Pulmonary Embolism           | <input type="checkbox"/> |
| Dizziness                           | <input type="checkbox"/> | Restless Leg Syndrome        | <input type="checkbox"/> |
| Eczema(atopic dermatitis)           | <input type="checkbox"/> | Seizures                     | <input type="checkbox"/> |
| Extreme Fatigue                     | <input type="checkbox"/> | Severe Headaches             | <input type="checkbox"/> |
| Hair Loss                           | <input type="checkbox"/> | Shortness of Breath          | <input type="checkbox"/> |
| Hay fever                           | <input type="checkbox"/> | Skin Infections              | <input type="checkbox"/> |
| Heart Disease                       | <input type="checkbox"/> | Skin Irritations             | <input type="checkbox"/> |
| Heart Murmur                        | <input type="checkbox"/> | Skin Rashes                  | <input type="checkbox"/> |
| Hepatitis                           | <input type="checkbox"/> | Stomach Ulcers               | <input type="checkbox"/> |
| Herpes Cold Sores                   | <input type="checkbox"/> | Thrombophlebitis(clotting)   | <input type="checkbox"/> |
| High/Low Blood Pressure             | <input type="checkbox"/> | Thyroid Problem              | <input type="checkbox"/> |

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

IF yes, please explain: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**D. SURGERY**

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 \_\_\_\_\_

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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 \_\_\_\_\_

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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: \_\_\_\_\_

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**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)

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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**

**Skin Problems (Please check all that apply)**

History of:	Frequent Sun Exposure	Yes <input type="checkbox"/> No <input type="checkbox"/>	Skin Cancer	Yes <input type="checkbox"/> No <input type="checkbox"/>
	Excessive Scarring	Yes <input type="checkbox"/> No <input type="checkbox"/>	Hair Loss	Yes <input type="checkbox"/> No <input type="checkbox"/>
	Eczema (atopic dermatitis)	Yes <input type="checkbox"/> No <input type="checkbox"/>	Psoriasis	Yes <input type="checkbox"/> No <input type="checkbox"/>

**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 &/or excision, and the exchange of medical information for purposes of medical treatment & 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:* \_\_\_\_\_