SKIN MATRX
INTEGRATED BEAUTY SOLUTIONS

General Information

Date:_____

Patient Name:_____

Last name **First name** **Middle name**

Home Phone:_____ **Cell Phone**:_____

Street Address:_____

City:_____ **State**:_____ **Zip**:_____

Email Address:_____

Age: _____ **Birthdate**:_____ **Sex**: M ☐ F ☐

Marital Status: S ☐ M ☐ W ☐ D ☐

Patient Employed By:_____ **Occupation**:_____

Referred By: _____

Medical History

In case of emergency who should be notified?_____ **Phone**:_____

Please give a specific reason for your visit today?_____

_____

Please list all allergies or intolerances (ie. Shellfish:)_____

_____

Are you under a doctor's care?_____

Doctor's Name:_____ **Phone Number**:_____

List all medications you are currently taking (including over the counter medicines, birth control pills or Vitamin E), along with the dosage:_____

_____

List all previous operations or major illness:_____

_____

List any other important medical information:_____

_____

Are you pregnant?_____ **Are you nursing**?_____

Do you drink caffeinated beverages?_____ **How many cups per day**?_____

Do you have a history of (circle correct answer):

Heart trouble	Yes	No	
Diabetes	Yes	No	
Pulmonary trouble	Yes	No	
Positive HIV/AIDS	Yes	No	
Thyroid trouble	Yes	No	
High blood pressure	Yes	No	
Bleeding problems	Yes	No	
Hepatitis	Yes	No	
Do you smoke cigarettes	Yes	No	
Use accutane or other similar medication	Yes	No	
Use of blood thinners	Yes	No	
Use of light sensitive medication	Yes	No	
Use of Retin-A or Retinol	Yes	No	
Use of bleaching or skin lightening cream	Yes	No	
Neurotoxin or filler treatment	Yes	No	If so when_____
Pacemaker or metal implants	Yes	No	

Height_____ Weight_____

I consent this information is correct and complete to the best of my knowledge and photographic documentation will be taken for personal use to illustrate my progression of results at Skin MatrX.

_____ _____

Signature of patient Date

I consent that these images can be used for medical, scientific, educational, or commercial purposes and are the property of Dr. Orloff and Skin MatrX.

_____ _____

Signature of patient Date