Welcome to Aesthetica

Please complete this form.
All information is confidential.
Thank You☺

PERSONAL INFORMATION

_____ _____
Date Age- (be honest!)

Reason For Visit Today: (Please include topic/s, be as specific as possible)

_____

Legal Name_____ Birthdate_____/_____/_____
Preferred Name (If Applicable)_____

Social Security #_____ Gender: Male / Female
Home Phone _____Cell _____Work_____
E-mail address_____ may we add you to our mailing list? Yes/no

Communication Preferences: May we contact you via (Please circle if YES)
Text Call Phone Message Email

Address_____
City_____State_____Zip_____

Employer_____Occupation_____

Single / Married / Separated / Divorced / Widowed / Co-habitating / Other
Spouse/Significant Other's Name:_____
Occupation_____
Employer_____cell#_____
Spouse Birthdate: _____/_____/_____

Family physician's:
Name_____
Address _____ City, State_____
Zip_____
Telephone _____Date of last physical exam_____

Name of person to contact in case of an emergency:
Name _____Phone_____
Relationship_____

MEDICAL INFORMATION

We are here to help you. Please answer as truthfully and completely as possible. Do you have:

Heart disease	Yes	No	Bulimia or Anorexia	Yes	No
Autoimmune Disorder	Yes	No	Chronic illness	Yes	No
Asthma	Yes	No	Mental Illness	Yes	No
Drug dependency	Yes	No	Blood Clotting Disorder	Yes	No
Anemia	Yes	No	Depression	Yes	No
Lung disease	Yes	No	High Blood Pressure	Yes	No
Blood Disorder	Yes	No	Cancer	Yes	No
Serious Accident	Yes	No	Diabetes	Yes	No
Birth Control	Yes	No	Sleep Apnea	Yes	No
Type_____			CPAP machine	Yes	No
Latex Allergies	Yes	No	Environmental Allergies	Yes	No
Other_____					

If you answered yes to any of the above, please explain:

_____

Do you have any allergies to medication? Yes / No
Please List: _____
Reaction: _____

Do you take any anti-depressants? Yes/No
Please List: _____
If yes, physician prescribing them: _____

Please list ALL medications and herbal supplements you are taking:

_____
_____
_____

(Feel free to give us your printed list if that is easier!)

List All Previous Surgeries (Including Cosmetic Procedures):

Type:_____Date:_____Dr._____
Type:_____Date_____Dr._____
Type:_____Date:_____Dr._____
Type: _____ Date:_____ Dr._____

Have you had any cosmetic procedures? Please list them above as well!
If yes, were you happy with the outcome? Yes/ No explain briefly:_____

CHILDBIRTH

Number of pregnancies? _____How much weight did you gain with each pregnancy?_____
Number of children? _____Age (s) of children _____ Did you breastfeed? Yes / No

LIFESTYLE

Do you currently smoke? Yes / No Packs per day? _____ Number of years? _____
Did you previously smoke? Yes/ No Number of years_____ When did you quit?_____

How many drinks containing alcohol do you drink a week? _____

Do you take Aspirin or Ibuprofen on a regular basis? Yes / No

Are you on a diet pill or diet program now? Yes / No Have you been in last 3 years? Yes / No

Do you take vitamins regularly? Yes / No

Height: _____ Weight: _____

Do you exercise? Yes / No Activity: _____ How often_____

Do you wear contacts? Yes / No Glasses? Yes / No
Who is your ophthalmologist_____

Do you have health insurance? Yes / No
Please provide card for photocopy.
Insurance company:_____
Policy Holder's Name:_____Date of Birth:_____

How did you hear about Dr. Anne Taylor and Aesthetica? (we would like to thank them.)_____