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)
____

Name_________________________ Birthdate_______/_______/_________

Social Security #_________________________ Male / Female /other

Home Phone ___________________________ Cell _________________ Work_________________________________

Address____

City ____State _________________ Zip ______________________________

E-mail address____ may we add you to our mailing list? Yes/no

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.)

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