

**To help us serve you better, please take a moment to complete this information.**

Date \_\_\_\_\_

Last Name \_\_\_\_\_ First \_\_\_\_\_ MI \_\_\_\_\_

Former Name \_\_\_\_\_ Nick Name \_\_\_\_\_

Date of Birth \_\_\_\_\_ Sex:  Female  Male

E mail \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home # \_\_\_\_\_ Cell # \_\_\_\_\_ Wireless Carrier \_\_\_\_\_

Employer \_\_\_\_\_ Phone # \_\_\_\_\_

Preferred phone number for contact:  Home  Cell  Work

May we send you an email for appointment reminder information?  Yes  No

For medical or additional scheduling information?  Yes  No

For marketing/ sales information?  Yes  No

May we send you regular mail?  Yes  No May we send you text messages?  Yes  No

**Marital Status:** Married Single Divorced Separated Widowed

**Ethnicity:** Hispanic or Latino Not Hispanic or Latino

**Race:** American Indian or Alaska Native Asian Black or African American

Hawaiian or other Pacific Islander Hispanic or Latino White

**Language:** English Spanish Other \_\_\_\_\_

Preferred Pharmacy \_\_\_\_\_ Location \_\_\_\_\_

Who may release medical/ appointment information to? Name \_\_\_\_\_

Relationship \_\_\_\_\_

Who may we contact in case of an emergency? Name \_\_\_\_\_

Relationship \_\_\_\_\_ Contact number \_\_\_\_\_

How did you hear of us? Internet Physician Mailer Billboard

Magazine Newspaper Staff member other

Friend/ client \_\_\_\_\_

## **Medical History**

Please list all of your current medications, including over the counter vitamins and supplements

- 1) \_\_\_\_\_
- 2) \_\_\_\_\_
- 3) \_\_\_\_\_

Do you take an Aspirin daily? Yes No

Do you use Retin-A? Yes No If yes, what do you use it for? Acne Anti-aging Other

Are you currently using Accutane? Yes No

Please list allergies to medications and over the counter products.  No known allergies

- 1) \_\_\_\_\_
- 2) \_\_\_\_\_
- 3) \_\_\_\_\_

Please circle any of the following products you are sensitive to:

Fragrances    Alpha Hydroxy-acids    Beta Hydroxy-acids    Hydrogen Peroxide    Hydroquinone    Retinol products

## **Health History**

Please mark any of the following health conditions that you have or experienced in the past

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Herpes Simplex (cold sores) | <input type="checkbox"/> Open lesions/ skin infections | <input type="checkbox"/> History of skin cancer _____                          |
| <input type="checkbox"/> Atypical moles              | <input type="checkbox"/> Auto Immune Disease           | <input type="checkbox"/> HIV   |
| <input type="checkbox"/> Hepatitis A, B or C         | <input type="checkbox"/> Active Acne                   | <input type="checkbox"/> Hyperpigmentation/ melasma/ mask of pregnancy         |
| <input type="checkbox"/> Rosacea                     | <input type="checkbox"/> Eczema or dermatitis          | <input type="checkbox"/> Psoriasis   |
| <input type="checkbox"/> Diabetes                    | <input type="checkbox"/> Thyroid disorder              | <input type="checkbox"/> Tuberculosis  |
| <input type="checkbox"/> Shingles                    | <input type="checkbox"/> Genital Herpes                | <input type="checkbox"/> Genital Warts   |
| <input type="checkbox"/> Stroke                      | <input type="checkbox"/> Keloid scarring               | <input type="checkbox"/> Facial Veins  |
| <input type="checkbox"/> Bleeding disorder           | <input type="checkbox"/> High Blood Pressure           | <input type="checkbox"/> High Cholesterol                                      |
| <input type="checkbox"/> Heart disease               | <input type="checkbox"/> Rheumatic fever               | <input type="checkbox"/> Mitral valve Prolapse / murmurs                       |
| <input type="checkbox"/> Osteopenia/ Osteoporosis    | <input type="checkbox"/> Colon polyp                   | <input type="checkbox"/> Cancer _____  |
| <input type="checkbox"/> Multiple Sclerosis          | <input type="checkbox"/> Headaches/ migraines          | <input type="checkbox"/> Varicose Veins/ Spider veins                          |
| <input type="checkbox"/> Bladder or kidney issues    | <input type="checkbox"/> Psychiatric disorder          | <input type="checkbox"/> Lung disorder (asthma, emphysema, chronic bronchitis) |

Please list any other pertinent medical history \_\_\_\_\_

Current height \_\_\_\_\_ Weight \_\_\_\_\_

Are you currently on a restricted diet?  Yes  No

Do you exercise regularly?  Yes  No

Do you wear contacts?  Yes  No

Please provide the dates (approximate ok) to the following tests:

Cholesterol \_\_\_\_\_ Thyroid \_\_\_\_\_

Colonoscopy \_\_\_\_\_ Were the results normal?  Yes  No

DEXA (bone density) \_\_\_\_\_ Were the results normal?  Yes  No

**(Females)** When was your last Pap smear? \_\_\_\_\_ Were the results normal?  Yes  No

When was your last Mammogram? \_\_\_\_\_ Were the results normal?  Yes  No

Number of Pregnancies \_\_\_\_\_ Live Births \_\_\_\_\_ Miscarriages \_\_\_\_\_

Have you gone through menopause?  Yes  No

Do you have any uterine abnormalities such as fibroids?  Yes  No

Do you have a history of infertility?  Yes  No

Do you have a history of DES exposure?  Yes  No

**(Males)** When was your last prostate specific antigen (PSA)? \_\_\_\_\_ Were the results normal?  Yes  No

Have you had the mumps?  Yes  No If yes, when? \_\_\_\_\_

Have you had a sperm count?  Yes  No If yes, when? \_\_\_\_\_

Have you fathered any children?  Yes  No If yes, how many? \_\_\_\_\_

Do you have problems with erectile dysfunction?  Yes  No

Do you have a Primary Care Physician?  Yes  No

Name \_\_\_\_\_ Phone # \_\_\_\_\_ City \_\_\_\_\_

**Family History** Do you have a family history of: (Please include the relationship- mother, father, etc.)

Breast cancer  Yes  No \_\_\_\_\_ Uterine cancer  Yes  No \_\_\_\_\_

Ovarian cancer  Yes  No \_\_\_\_\_ Prostate cancer  Yes  No \_\_\_\_\_

Colon cancer  Yes  No \_\_\_\_\_ Other \_\_\_\_\_

**Social History**

Smoking History:  Currently a smoker  Former Smoker  Never a smoker

Packs per day \_\_\_\_\_ Number of years smoked \_\_\_\_\_ Year quit \_\_\_\_\_

Alcohol: Drinks per week \_\_\_\_\_

Do you use recreational drugs?  Yes  No \_\_\_\_\_

**Surgical History**- please mark all surgeries you have had and include the dates they were performed

- Hysterectomy \_\_\_\_\_ Mastectomy \_\_\_\_\_ Prostate removed \_\_\_\_\_  
Pacemaker \_\_\_\_\_ Tubal Ligation \_\_\_\_\_ Cosmetic surgery \_\_\_\_\_  
Joint replacement (metal implants) \_\_\_\_\_ other \_\_\_\_\_

Have you ever had any complications with anesthesia?  Yes No

**Skin/ Aesthetic History**

What types of products/ product line are you using now? \_\_\_\_\_

In your opinion, what type of skin do you have?

- Dry Normal to dry Normal Normal to oily Oily Problem/ blemished

How easy is it to tan your skin? always burn burn at first, but can get a light tan

- rarely burn, always tan never burn, easily tan always tan

Have you ever had any of the following? Please include approximate dates.

- IPL (fotofacial) \_\_\_\_\_ Peels \_\_\_\_\_ Fillers \_\_\_\_\_ Botox/ Dysport/ Xeomin \_\_\_\_\_  
Vein treatment \_\_\_\_\_ Massage \_\_\_\_\_

Have you had laser resurfacing, facial procedures or chemical peels in the past 3 months? Yes No

If yes, what type \_\_\_\_\_

**Authorizations**

I consent to the taking of photographs for the purpose of documentation and future comparison. (Initial \_\_\_\_\_)

I authorize the release of information to/ from my primary care physician or specialist if deemed necessary for treatment. (Initial \_\_\_\_\_)

I understand insurance companies may not cover any procedures performed. (Initial \_\_\_\_\_)

Payments for all procedures/ services are to be paid at the conclusion of each visit. (Initial \_\_\_\_\_)

I understand that procedure packages are non-transferable. (Initial \_\_\_\_\_)

I authorize that the above information is up to date and correct to the best of my knowledge. (Initial \_\_\_\_\_)

Signature \_\_\_\_\_ Date \_\_\_\_\_

Thank you,

Dr. Rebecca de la Torre

And the Allura Skin, Laser and Wellness clinic staff