SOUTHERN CHIC MEDICAL AESTHETICS

General Patient Intake Form

Patient Name: (Last)_____(First)_____(MI)_____
Patient Address: _____
City: _____ State: _____ Zip: _____
Home Phone: _____Cellular: _____
Email:_____
Birthdate: _____Age: _____Sex: M F
Country of Birth: _____ Country of Parents' Birth: _____

Employment Information:
Patient Employer: _____ Occupation: _____
Employer Address: _____
City: _____ State: _____ Zip_____
Work phone No: _____Ext. _____
Social Security: _____Drivers License: _____

In Case of Emergency:
Name: _____Relationship: _____ Phone:_____
Patient's Spouse: _____ Phone:_____
Family Physician: _____ Phone:_____
Referred by: _____

Past History: (Please check if you have had any of the following):
☐ Allergies, Type: _____ ☐ Birth defects or abnormalities
☐ Exposed to tuberculosis ☐ Measles ☐ Scarlatina ☐ Influenza
☐ Mumps ☐ Diphtheria ☐ Rheumatic
☐ Fever German Measles (3 day) ☐ Polio ☐ Whooping Cough
☐ Frequent Colds ☐ Chickenpox ☐ Tonsillitis ☐ Scarlet Fever
☐ Pneumonia ☐ Diabetes:Type: _____
☐ Cancer, Type:_____ ☐ Other Diseases _____
☐ Operations:(dates) _____
Current Medications (vitamins, birth control pills): _____
Any mood altering or depression medication:_____
Allergies to medicines, foods, etc_____

Family History:
Father: Health _____ Age _____ Deceased _____ at age _____ Cause _____
Mother: Health _____ Age _____ Deceased _____ at age _____ Cause _____
# of siblings:_____ # living_____ #deceased: _____ Cause _____

Family Diseases: Check diseases known in your blood relatives (not yourself)
☐ High blood pressure ☐ Allergy ☐ Heart trouble ☐ Anemia
☐ Migraine ☐ Bleeding (abnormal) ☐ Dropsy ☐ Epilepsy
☐ Strokes ☐ Cancer ☐ Diabetes ☐ Nervous breakdown
☐ Kidney disease ☐ Syphilis or (bad blood) ☐ Suicide ☐ Obesity
☐ Arthritis ☐ Rheumatic ☐ Fever
☐ Other _____

Examinations:
Date of last physical examination _____ Reason:_____

Hospitalizations _____ Dates _____ Reason:_____
X-Rays: Chest _____Stomach _____ Gallbladder _____ Kidney _____Colon _____
Other _____Date of last laboratory tests:_____
Electrocardiogram (heart tracing) _____ Date of last pap (cancer smear): _____

Do you now have or have had any of the following?

☐ Itching ☐ Eczema ☐ Hives ☐ Joint pains ☐ Muscle aches
☐ Arthritis ☐ Limitation of motion ☐ Backache ☐ Leg pains ☐ Heel Pains
☐ Pain or stiffness (neck) ☐ Goiter ☐ Swelling, enlarged glands
☐ Asthma ☐ Lung disease ☐ Raise sputum ☐ Emphysema Bronchitis
☐ Heart trouble ☐ High blood pressure ☐ Shortness of breath ☐ Palpitation or fluttering ☐
Chest pain ☐ Lips or nails turn blue ☐ Tire easily ☐ Swelling of ankles
☐ Indigestion ☐ Nausea or vomiting ☐ Abdominal pain ☐ Gas or bloating ☐ Diarrhea
☐ Hard bowel movements No. of bowel movements - daily _____ ☐ Colitis
☐ Jaundice ☐ Hemorrhoids (piles) ☐ Bleeding or black stools ☐ Hernia
☐ Urinary System ☐ Kidney disease ☐ Bladder disease ☐ Kidney stones
☐ Painful urination ☐ Pus or blood in urine ☐ Albumen or sugar in urine
☐ Dribbling of urine ☐ Varicose veins ☐ Nervousness or anxiety
☐ Trouble sleeping ☐ Headaches ☐ Bored or depressed ☐ Nervous breakdown
☐ Fainting ☐ Convulsions ☐ Numbness ☐ Loss of consciousness ☐
Neuritis or Neuralgia ☐ Paralysis

Menstrual History:

Menstruation began at age:_____28 day cycle? _____ If no, how many days? _____
Duration of bleeding:_____Pain with periods?_____
Amount of flow : Light _____ Med. _____Heavy _____
Date of 1st day of last: _____menstrual period:_____
Bleeding between periods:_____Bleeding after intercourse:_____
Irritation or discharge:_____Itching or burning _____

Do you currently have any medical concerns? Please List:_____
_____
_____

Financial Policy:

We are honored to be of service to you. This is to inform you of our billing requirements and our financial policy. Please be advised that payment for all services will be due at the time services are rendered, unless prior arrangements have been made.

I agree that should this account be referred to an agency or an attorney for collection, I will be responsible for all collection costs, attorney's fees and court costs.

I have read and understand all of the above and have agreed to these statements.

_____ _____
Patient's Signature Date

All Statements on this patient intake form are accurate and true to the best of my knowledge. I understand that treatments will be based on the information provided herein. If I willingly withhold knowledge from my treating physician, I accept full liability from any consequences arising there from.

_____ _____
Patient's Signature Date