

NAME: _____ DOB: _____ DATE: _____

Circle your areas of interest, services you desire, or simply detail your interests below:

- Sun Damage Rosacea Broken Capillaries Acne Scars Enlarged Pores Brown Spots Red Spots
 Smartlipo™ Droopy Brow, Jowls, Neck, Eyelids Skin Tightening Body Sculpting Stubborn Fat Cellulite
 EyeTight™ NeckTight™ Eye Bags Restylane® Perlane® Juvéderm™ Evolence® Radiesse®
 Wrinkles around the Mouth / Eyes Sagging Chin/Neckline Fractional Laser Resurfacing (Fraxel®/Thermage®)
 Spider Veins Telangiectasias Facial Veins Varicose Veins Endovenous Closure® EVLT™ Sclerotherapy
 Fine lines & Wrinkles Stubborn Acne Uneven Texture Hyperhidrosis (excessive sweating) Laser Hair Removal
 BOTOX® PhotoRejuvenation Mesotherapy Tummy Tuck Lipodissolve Liposuction ThreadLift™
 Dark Circles TummyTight™ Buttock or Breast Augmentation / Reduction / Lift Fat Transfer VolumaLift™
 Vaginal Rejuvenation Hymen Restoration G-Spot Enhancement Excessive or Uneven Labia Labiaplasty

My specific concerns: _____

Health History (Please circle or complete)

1. Do you have any history of scarring of your skin?	No	Yes	13. Taken Accutane (isotretinoin)	No	Yes	
2. Have you ever had a blood hormonal work up?	No	Yes	14. Using Retin-A or alpha/beta hydroxyl acids?	No	Yes	
3. Have you ever had a laser procedure?	No	Yes	FOR WOMEN ONLY (N/A = not applicable):			
4. Ever had skin resurfacing/chemical peels?	No	Yes	15. When was your last period	_____		
5. History of cold sore/herpes/recurrent skin infection?	No	Yes	16. Was it normal?	N/A	No	Yes
6. History of neurologic disease or muscle weakness?	No	Yes	17. Are you pregnant?	N/A	No	Yes
7. History of poor or slow healing/keloid scars?	No	Yes	18. Are you trying to get pregnant?	N/A	No	Yes
8. History of bruising or bleeding disorder?	No	Yes	19. Using anything to prevent pregnancy?	N/A	No	Yes
9. History of skin cancer or suspicious moles?	No	Yes	20. History of polycystic ovaries?	N/A	No	Yes
10. Taking ginkgo, vitamins or any other supplements?	No	Yes	21. Melasma (mask of pregnancy)?	N/A	No	Yes
11. Taking prescription medications/alcohol regularly?	No	Yes	22. Change in skin color with pregnancy?	N/A	No	Yes
12. Any allergies to medications/latex/sulfites?	No	Yes				

I have answered all questions truthfully to the best of my ability. I have had the opportunity to ask about any question that was unclear and have this explained to me to my satisfaction. I will not hold anyone responsible for any adverse reaction that I may have as a result of any false information or information I have not disclosed.

Client Signature: _____ Date: _____

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Ministering the Love of God... Through Beauty

Personal Information **How do you prefer to be addressed:** _____

Name: _____ Birth date: _____ - _____ - _____ Age: _____
LAST FIRST MI MAIDEN/PREVIOUS

Current Status: M / S / D / W / _____

Address: _____ City/State: _____ Zip: _____

Home: (_____) _____ - _____ Mobile: (_____) _____ - _____

E mail: _____ Alt email: _____

Employer: _____ Phone: (_____) _____ - _____

Contact in case of Emergency: _____ Phone: (_____) _____ - _____

SSN: _____ - _____ - _____ Driver's Lic#: _____

Contact Information

Best way to be reached: Mobile Home Work E Mail Letter _____
CIRCLE ALL THAT APPLY

Best day and time to call for reminders/follow-up: _____

If you are not in, with whom may we leave a message? No one / _____

How may we confirm appointments / follow-up? (circle all that apply / cross out what must not be used)

Call: Mobile / Home / Work Voice mail Text Message Email Letter Postcard _____

How do you want to learn about specials, Open Houses, promotions, or the latest in aesthetics/wellness?

No thank you / Call: Mobile / Home / Work Voice mail Text Message Email Letter Postcard

How did you find us? Referral Source: _____
IF THE INTERNET, PLEASE LIST SITE AND/OR SEARCH WORDS

Check here if you are a patient of Ocean Ob/Gyn Associates

If someone recommended you, may we thank them? (Circle one) YES NO (I prefer to remain anonymous)

Client Signature: _____ **Date:** _____

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