SOCAL MD + Aesthetics

PATIENT PERSONAL INFORMATION

GENERAL

Last Name		First Name		Middle	
Home Address				APT	
City		State		Zip Code	
Home Phone		Cell Phone		Birthplace	
Date of Birth		Age		Sex	
Drivers License #		Email Address			
Marital Status		Spouse's Name			

Who may we THANK for referring you to us?		Phone	

EMPLOYMENT

Employer Name			Occupation		
Employer Address					
Employer City		Employer State		Employer Zip Code	
Employer Phone					

INSURANCE INFORMATION

Do you have medical insurance?		Is your insurance a PPO?	

PRIMARY INSURANCE (if you have insurance, otherwise leave blank)

Insurance Company		Group Number		Policy Number	
Insured's Name				Insured's DOB	
Relationship to Insured					

SECONDARY INSURANCE (if you have secondary insurance, otherwise leave blank)

Insurance Company		Group Number		Policy Number	
Insured's Name				Insured's DOB	
Relationship to Insured					

EMERGENCY CONTACT

Name		Relationship		Phone	

AUTHORIZATION

I understand that this office will submit claims to the listed insurance company, but that I am ultimately responsible for this account. I also authorize the release of any medical information necessary to process my claim.

Signature		Date	

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ROUTINE HEALTH ASSESSMENT - FAMILY/PERSONAL HISTORY

Name		Age		Date of Birth		Date	
Marital Status	☐ Single ☐ Married ☐ Domestic Partner ☐ Divorced ☐ Widowed			Birth Place			

LIVING	MEDICAL CONDITIONS	DECEASED	CAUSE OF DEATH
Father: _____ Age		_____ Age at death	
Mother: _____ Age		_____ Age at death	
Sibling 1: _____ Age NA		_____ Age at death	
Sibling 2: _____ Age NA		_____ Age at death	
Child 1: _____ Age NA		_____ Age at death	
Child 2: _____ Age NA		_____ Age at death	

List blood relatives medical illnesses: *(eg Cancer, Leukemia, Diabetes, Hearth Trouble, High Blood Pressure, Stroke, Epilepsy, Thyroid, Alcoholism, Tuberculosis, Suicide)*

Relative:		Relative:	

SOCIAL HISTORY

Education Level _____ yrs in High School, _____ yrs in College

Do you use a seatbelt? Yes Do you use a helmet? Yes

Do you smoke cigarettes? ☐ ☐ If so, _____ packs per day

If you smoked in the past, for _____ years and I quit on _____/_____/_____

Do you use: ☐ Cigars ☐ Pipe ☐ Chewing Tobacco ☐ Snuff

Alcoholic Beverages: ☐ Never ☐ Rarely ☐ Moderate ☐ Daily

Have you ever wanted help with alcohol now or in the past?	☐	☐
Do you use recreational drugs?	☐	☐
Do you or your partner use IV drugs?	☐	☐
Have you ever wanted help with drugs now or in the past?	☐	☐
Are you sexually active now ☐ Vaginal ☐ Anal ☐ Oral		
Have you had more than 1, or a new, partner in the past year?	☐	☐
Is/are your partner(s): ☐ Male ☐ Female ☐ Both		
Have you ever been hit or pushed by a partner?	☐	☐
Do you take precautions against STD'S?	☐	☐
Have you been put at risk for STD or HIV?	☐	☐
Do you wish to have an HIV test?	☐	☐
Have you ever had a tattoo?	☐	☐
Do you have an Advance Directive (Living Will)?	☐	☐
If not, would you like information?	☐	☐

PAST MEDICAL HISTORY

Any broken bones, dislocations or head injuries?	☐	☐
Any serious accidents?	☐	☐
Have you been hospitalized for any illness?	☐	☐

If so, why?

SURGICAL HISTORY (Select all that apply)

☐ Tonsillectomy ☐ Appendectomy ☐ Hysterectomy

☐ Gall Bladder Removed ☐ Ovaries Removed ☐ Mastectomy

☐ Breast Lump Removed Other:_____

CONDITIONS (Select all that apply)

☐ Cancer ☐ High Blood Pressure ☐ Heart Disease ☐ Diabetes

☐ Depressions ☐ Lung Disease ☐ Arthritis or Rheumatism

☐ Migraines ☐ Anemia ☐ Jaundice/Liver Disease ☐ STDS

☐ Seizures/Convulsions ☐ Rheumatic Fever ☐ Meningitis

☐ Tuberculosis or + TB Test ☐ Any Bone or Joint Disease

☐ Kidney Disease ☐ Kidney Stones ☐ Hay Fever ☐ Measles

☐ Hives/Eczema ☐ Mumps ☐ Chicken Pox ☐ Whooping Cough

☐ Pneumonia ☐ Polio ☐ Freq Infections/Boils ☐ Skin Disease

☐ Freq Colds or Sore Throats ☐ Blood Transfusions

Weight at age 18? ____ Maximum weight ____ When? _____

PREGNANCY HISTORY

# of Pregnancies ____ # Living Children ____ # of Deliveries ____

# of C-Sections ____ # of Abortions ____ # Miscarriages ____

# of Tubal Pregnancies ____ Any pregnancy complications? ____

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ALERGIES	REACTION	MEDICATIONS (List strength and frequency)	
Penicillin or Sulfa		1)	
Erthromycin		2)	
Aspirin, Codeine, Morphine		3)	
Iodine		4)	
Adhesive Tape		5)	
Any foods or other drugs		6)	

CONSTITUTIONAL SYMPTOMS			GASTROINTESTINAL			NEUROLOGICAL		
Fever	☐	☐	Stomach trouble or ulcer	☐	☐	Headache ☐Freqent ☐Severe	☐	☐
Chills	☐	☐	Nausea or vomitting	☐	☐	Dizziness	☐	☐
Night sweats	☐	☐	Heartburn/indigestions	☐	☐	Numbness	☐	☐
Extreme tiredness	☐	☐	Constipation	☐	☐	Paralysis	☐	☐
Recent weight change	☐	☐	Diarrhea	☐	☐	Fainting	☐	☐
Change in appetite	☐	☐	Hemorrhoid/rectal bleed	☐	☐	Loss of consciousness	☐	☐
EYES, EARS, NOSE & THROAT			Black Stool	☐	☐	Seizure	☐	☐
Blurred vision	☐	☐	Difficulty swallowing	☐	☐	**MENTAL HEALTH**		
Double vision	☐	☐	Do you take laxatives?	☐	☐	Anxiety	☐	☐
Ear pain	☐	☐	Change in bowel habits	☐	☐	Hallucinations	☐	☐
Ringing in the ears	☐	☐	**GENITOURINARY**			Treated for mental disorder	☐	☐
Hearing loss	☐	☐	Kidney disease or stones	☐	☐	Feeling down or depressed	☐	☐
Nasal discharge	☐	☐	Painful urination	☐	☐	Lack interest/pleasure	☐	☐
Sore throat	☐	☐	Blood in urine	☐	☐	**HABITS**		
CARDIOVASCULAR			Frequent urination	☐	☐	Trouble sleeping	☐	☐
Chest pain	☐	☐	Frequent urination at night	☐	☐	Exercise	☐	☐
Palpitations	☐	☐	**SKIN**			**MEN ONLY**		
Hand/feet/ankle swelling	☐	☐	Rash	☐	☐	Conduct testicular exams	☐	☐
RESPIRATORY			Itching	☐	☐	Erectile problems?	☐	☐
Cough ☐chronic ☐frequent	☐	☐	**HEMATOLOGIC**			**WOMEN ONLY**		
Coughing up blood	☐	☐	Easy bleeding	☐	☐	Conduct breast exams	☐	☐
Shortness of breath	☐	☐	**ENDOCRINE**			Date of last period		
Stop breathing with sleep	☐	☐	Abnormal thirst	☐	☐	Regular periods?	☐	☐
MUCULOSKELETAL			Excessive urine volume	☐	☐	Usual length length in days		
Paint in joints	☐	☐	Eat excessively	☐	☐	Cycle _____ days		
Back pain	☐	☐	Hot flashes	☐	☐	Pain or cramps	☐	☐
Muscle pain	☐	☐	Thyroid problems	☐	☐	Abnormal vaginal discharge	☐	☐