ALLURA
skin, laser & wellness clinic

FEMALE PATIENT INFORMATION

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

Today's Date: _____________

Last Name: _________________________________ First Name: __________________

MI: _____ Nick Name: _____________________

Date of Birth: ____________________ Age: ___________________

Street Address: ____

P.O. Boxes are insufficient for ordering pellets, please use mailing address.

City: ___________________________________ State: ____________ Zip Code: _________

Email address **(Please Print Legibly):**

____

YOUR EMAIL ADDRESS IS OUR PREFERRED MEANS OF CONTACTING YOU

Home Number: ____________________________ Cell Number: ___________________________

Employer: ________________________________ Work Number: __________________________

Occupation: ____

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 notifying you of our monthly specials? □ Yes □ No
May we send you regular mail? □ Yes □ No

Marital Status:
□ MARRIED □ DIVORCED □ SINGLE or NEVER MARRIED
□ WIDOW □ LIVING WITH SIGNIFICANT OTHER

Ethnicity: □ Hispanic □ Asian □ Not Hispanic or Asian

Language: □ English □ Spanish □ Other ________________

In case of an **emergency**, whom should we notify?

Contact Name: _______________________________________ Relationship: _______________

Contact Number: _______________________

Who may we release **medical or appointment information** to?

Name: ________________________________ Relationship: ____________________________

Preferred Pharmacy: ____

Location: ______________________________ Phone number (if available): _________________

Preferred Lab:
____

Location: _______________________________

Physician Name: ____ Specialty: ________________

Location: ______________________________ Phone number (if available): __________________

How did you hear of us? (Please check all that apply):

□ Internet □ Magazine □ Newspaper
□ Billboard □ Mailer □ Staff Member
□ Friend or Client ______________________________________
□ Physician: ____
□ Other: ____

We are honored that you have chosen Allura Skin, Laser, and Wellness Center.
Please state the reasons for your visit:

____

____

Medical History

Weight: ___________ **Height**: ____________

Drug Allergies: □ NO □ YES List allergies: _________________________________

Prescribed medications that you are currently taking and the dosage amount for each one:

___________________________________ ____

___________________________________ ____

___________________________________ ____

___________________________________ ____

Please list the **vitamins, supplements, and herbs** that you are taking:

___________________________________ ____

___________________________________ ____

Do you take Aspirin or other anti-inflammatory medications daily? □ Yes □ No
Are you currently taking Accutane? □ Yes □ No

Have you ever been tested for **HIV**? □ Yes □ No
If yes, results were □ Negative □ Positive

Have you been diagnosed with **Hepatitis?** □ Yes □ No
If yes, please check which type:
□ Hepatitis A □ Hepatitis B □ Hepatitis C □ Other

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Habits:

Do you smoke? □ Yes □ No

Age that you started smoking: _____

Number of cigarettes per day: _____

Do you drink alcohol? □ Yes □ No

On the average, how many drinks per week? _________

Do you use recreational drugs? □ Yes □ No

How often do you exercise? □ Daily □ 0-2 times per week □ 3-5 times per week

Skin Care History:

What types of **skin care products or product line(s)** are you currently using?

____

____

Are you sensitive to skin care products? □ NO □ YES

If yes, is sensitivity due to: □ Fragrances □ Irritation □ Rash □ Dryness

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 been treated for **acne with** □ **oral medications,** □ **creams, or** □ **Accutane**?

Have you ever had any of the following **procedures** (please check all that apply)?
Please include approximate year:

□ Body Contouring (Thermage, VaserShape, or Other): ______________________________
□ Botox/Dysport/Xeomin: ____
□ Chemical Peel____
□ Facials: ____
□ Fillers: ____
□ Fractional Lasers (Fraxel or CO2 or Sublative or Other):___________________________
□ Hair Removal (Electrolysis, Wax or Dermablading): _______________________________
□ IPL (intense pulse light) or FotoFacial: ____
□ Laser Hair Removal: ____
□ Microderms: ____
□ Permanent Make-Up: ____
□ Skin Tightening of Face or Eyes (Thermage or Other): ____________________________
□ Teeth Whitening: ____
□ Vein Treatment: ____

Have you had any **adverse reactions** to any of the treatments listed above? □ NO □ YES

If yes, please explain the reactions:

____

____

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Please mark all that apply:

- ☐ Active acne
- ☐ Age Spots//Brown spots
- ☐ Allergies
- ☐ Anemia
- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Atypical Moles
- ☐ Augmentation of Breasts
- ☐ Bladder Infections
- ☐ Bleeding Disorders
- ☐ Blood Cancers
- ☐ Blood clots
- ☐ Blood Transfusions
- ☐ Breast Reduction
- ☐ Celiac Disease
- ☐ Chronic pain
- ☐ Cold sores
- ☐ Colon CA
- ☐ Colon Polyps
- ☐ Cosmetic surgery
- ☐ Crohn's Disease
- ☐ Degenerative Disc Disease
- ☐ Depression
- ☐ Diabetes
- ☐ Eating Disorder
- ☐ Eczema/psoriasis
- ☐ Emphysema/COPD
- ☐ Facial hair growth
- ☐ Facial Veins
- ☐ Fibrocystic breasts
- ☐ Fibromyalgia
- ☐ Gluten Intolerance
- ☐ Goiter
- ☐ Hair Loss
- ☐ Hair Thinning
- ☐ Hashimoto's
- ☐ Headaches/Migraines
- ☐ Heart Attack
- ☐ High Cholesterol
- ☐ History of skin cancer
- ☐ Hyperthyroid/Graves'
- ☐ Hypertension
- ☐ Hypothyroid
- ☐ Irregular heart rate
- ☐ Irritable Bowel Syndrome
- ☐ Keloid scarring
- ☐ Kidney Stones
- ☐ Lactose Intolerance
- ☐ Leg Veins
- ☐ Lung Cancer
- ☐ Lupus Arthritis
- ☐ Metabolic Syndrome
- ☐ Multiple Sclerosis
- ☐ Murmur
- ☐ Osteopenia/osteoporosis
- ☐ Reflux
- ☐ Rheumatoid Arthritis
- ☐ Rosacea
- ☐ Scars
- ☐ Scleroderma
- ☐ Sleep Apnea
- ☐ Stretch Marks
- ☐ Stroke
- ☐ Sun-damaged skin
- ☐ Thyroid Cancer
- ☐ Thyroid Nodule
- ☐ TIA
- ☐ Varicose veins
- ☐ Ulcers
- ☐ Other illnesses not listed above: ___________________________________

Surgeries:
List all **major surgeries**:

____

____

Please list **outpatient procedures, surgeries and hospitalizations** (including year and reason):

____

____

Have you had any major accidents: ☐ Yes ☐ No

Family Medical History:

- ☐ Alcohol or Drug Abuse
- ☐ Bladder Cancer
- ☐ Breast Cancer
- ☐ Celiac Disease
- ☐ Cervical Cancer
- ☐ Colon Cancer
- ☐ Dementia
- ☐ Depression
- ☐ Diabetes
- ☐ Heart Disease/MI
- ☐ Hereditary Blood Disorders
- ☐ High Cholesterol
- ☐ Hypertension
- ☐ Lung Cancer
- ☐ Lupus
- ☐ Osteoporosis/Osteopenia
- ☐ Ovarian Cancer
- ☐ Parkinson's Disorders
- ☐ Psychiatric Disorders
- ☐ Prostate Cancer
- ☐ Rheumatoid Arthritis
- ☐ Skin Cancers
- ☐ Stroke
- ☐ Suicide
- ☐ Thyroid Cancer
- ☐ Thyroid Disease
- ☐ Uterine Cancer

Other illnesses or disease not listed:

____

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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 the treatment.
Initial _________

I understand that **my insurance company will not cover any of the procedures performed**.
Initial _________

Payments for all procedures or 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: _____________

Provider Signature: ____ Date: _____________

Please complete the remaining pages for your
Bio-Identical Hormone Replacement Therapy Consultation and Insertion

Health Maintenance:			**Normal:**	
Mammogram in the previous 24 months:	□ YES	□ NO	□ YES	□ NO
Bone density in the previous 24 months:	□ YES	□ NO	□ YES	□ NO
Medical/Gyn exam in previous 24 months:	□ YES	□ NO	□ YES	□ NO
Pap Smear in the previous 24 months:	□ YES	□ NO	□ YES	□ NO
Pelvic Ultrasound in the previous 24 months:	□ YES	□ NO	□ YES	□ NO
Performs Regular Self Breast Exams:	□ YES	□ NO	□ YES	□ NO

OB/GYN History:
Number of pregnancies _______
Number of live birth: _______
Number of miscarriages: _______

Sexual orientation: □ Heterosexual □ Homosexual □ Bisexual

Check all that apply:

□ Regular Periods	□ Irregular Periods	□ Abnormal Pap
□ Abnormal Uterine Shape	□ Breast Cancer	□ C-Section(s)
□ Cone Biopsy of cervix	□ Colposcopy	□ Cryogen Treatment
□ Fibroids	□ Genital Herpes	□ H/O Pelvic Infections
□ Hysterectomy	□ Infertility	□ Laser Treatment for cervix
□ Menopause	□ Ovarian Cancer	□ STD(s)
□ Uterine Ablation	□ Uterine Cancer	□ PCOS (polycystic ovarian syndrome)

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What type of contraception are you currently using (check all that apply)?

□ NONE	□ Condoms	□ Depo Provera	□ Diaphram
□ Foam	□ Hysterectomy	□ IUD	□ Natural Family Planning
□ Norplant	□ Oral Contraception	□ Plan B	□ Tubal Ligation
□ Vasectomy	□ Withdrawal		

SYMPTOM CHECKLIST

Please circle the symptoms you are experiencing and the frequency or severity of the symptoms:

Estrogen Related Symptoms:

Night Sweats:	□<3 times/week		□ 1-3 times per night	□ >3 times/night
Sleeping problems:	□ Never		□ 1-3 awakenings/week	□ Sleep disturbance every night
Hot flashes/warm flushing:	□ Never		□ 1-3 flashes/night	□ Frequently-Daily/Nightly
Pain with intercourse:	□ Never	□ Once in a while	□ More often	□ Always
Vaginal dryness:	□ Never	□ Once in a while	□ Worsening	□ Always
Urine leakage:	□ Never	□ When I cough, sneeze, or exercise		□ Daily

Testosterone Related Symptoms:

Sexual Desire/Libido:	□ Not a problem		□ Less Desire	□ No Desire
Difficulty Concentrating:	□ Not a problem		□ Worsening	
Memory Loss:	□ Not a problem		□ Worsening or more forgetful	
Foggy Thinking:	□ Not a problem		□ Worsening	
Muscle Pain	□ Never	□ Occasionally	□ More Often	□ Daily
Joint Pain	□ Never	□ Occasionally	□ More Often	□ Daily

Estrogen and Testosterone Related Symptoms:

Mood Swings:	□ No	□ Before my Periods	□ Getting worse & not sure why	
Migraines/Headaches:	□ Never	□ 1-2 times/month	□ More frequent/getting worse	□ Daily
Depression:	□ No	□ Sad more than usual	□ Affecting my job/relationships	
Anxiety:	□ No	□ Worsening	□ Affecting my job/relationships	

Please initial then sign below:

I authorize the above information is up to date and correct to the best of my knowledge.
Initial ___________

Signature: ____ **Date:** ____________

Provider Signature: ____ **Date:** _____________

Thank you for completing the Health History Form.

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