Have you ever had or are you currently experiencing any of the following?

Acne	Y	N	Lupus/ SLE	Y	N
Anorexia	Y	N	Lymph Disorder	Y	N
Anemia	Y	N	Migraines	Y	N
Asthma	Y	N	Multiple Sclerosis	Y	N
Bleeding Tendency	Y	N	Pacemaker/ Electrical Implant	Y	N
Blood Disorder	Y	N	Poor Wound Healing	Y	N
Bruising Tendency	Y	N	Respiratory Disease	Y	N
Cancer-Active	Y	N	Rheumatoid Arthritis	Y	N
Cancer- Remission	Y	N	Raynaud	Y	N
Cardiac Disorder	Y	N	Scleroderma	Y	N
Cold Sores	Y	N	Shingles	Y	N
Current Cold/Flu	Y	N	Sjogrens	Y	N
Diabetes	Y	N	Skin Rash Currently	Y	N
Epilepsy/ Seizures	Y	N	Staph Infection/MRSA	Y	N
Hepatitis Type	Y	N	Stroke	Y	N
High Blood Pressure	Y	N	Thyroid Disorder	Y	N
High Cholesterol	Y	N			
HIV	Y	N			
Infection Currently	Y	N			
Kidney Disease	Y	N			
Leukopenia	Y	N			
Liver Disease	Y	N			
Low Blood Pressure	Y	N			

Please list any other conditions:

_____

_____

_____

If you answered yes to any of the above questions, please state how this medical condition is being managed. Name of Physician, Name of Medications, other Treatments, etc.

_____

_____

_____

_____

I attest that the above information is accurate to my knowledge and will alert FP@PD if any information about my health changes.

Client Signature:_____ Date:_____

Witness Signature:_____ Date:_____

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HORMONE QUESTIONAIRE

Name:_____ DOB: _____ Date: _____

	MILD					MODERATE				SEVERE
	1	2	3	4	5	6	7	8	9	10
PROGESTERONE										
Difficulty Concentrating										
Can't Sleep (Insomnia)										
Depressed or Unhappy										
Anxious										
Headaches										
Moodiness/Emotional Swings										
Painful and Swollen Breasts										
Weight Gain/Bloating										
PMS										
ESTROGEN										
Night Sweats										
Memory Loss										
Hot Flashes										
Vaginal Dryness										
Dry Hair/Skin										
Incontinence										
Frequent Urinary Infection										
Inability to Reach Orgasm										
Painful Intercourse										
TESTOSTERONE										
Loss of Libido										
Lack of Desire to be Intimate										
Loss of Motivation										
Flat Mood										
Diminished Well Being										

GENERAL WELL BEING		
Change of Bowel Movement	How many per day?	
Change of Weight	Increase:	Decrease:
Change of Stress LEVEL	Yes/No	Current stress level:

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Medications/Supplements

Medications/Supplements	Reason for taking	Date Began	Dose

Have you had any allergic reaction to the following?

Local anesthetics (ex: Lidocaine)	Y	N	
Penicillin or other antibiotics	Y	N	**If yes, please explain** _____
Sulfa drugs	Y	N	
Latex	Y	N	
Sedatives	Y	N	
Blood Iodine	Y	N	
Aspirin	Y	N	
Drugs	Y	N	**If yes, please explain** _____
Food	Y	N	**If yes, please explain** _____
Other	Y	N	**If yes, please explain** _____

If yes, what happens? _____

Please list any relevant family history: _____

_____

_____

List Yes(Y) No (N) Past (P) regarding use of the following:

Steroids: Y N P **If yes, for what condition and what dosage?** _____

Smoking: Y N P **If yes, how much per day?** _____

****Smoking in any amount compromises the healing process and may negatively affect the outcome of your treatment.**

Analgesics: Y N P **Caffeine:** Y N P **Ounces per day if Yes:** _____

Alcohol: Y N P **If yes, How much per week?** _____

Recreational Drugs: Y N P

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PATIENT INFORMATION AND INTAKE FORM

Date: _____

_____
First **Middle** **Last**

DOB: _____ Age: _____

Address: _____

City: _____ State: _____ Zip: _____

Telephone: _____ Work Number: _____ OK to Email or Leave Message? Y / N

Email: _____ Location: _____

How did you hear about us? _____

Ethnic Background: _____

Marital Status (please circle) Married Single/Divorce Widow Living with Significant other

If emergency please contact: _____ Contact number: _____

Relationship to you: _____

PATIENT MEDICAL HISTORY

State the reason(s) for your visit and describe any symptoms you are experiencing:

_____

_____

_____

Immunizations/Surgeries (including tonsils, gallbladder, appendix, cosmetic):

Procedure	Year

No	Yes	Do you take any prescription or over the counter medications? (Include herbal supplements) Please list:

No	Yes	Do you currently, or have you ever had any of the following conditions?	Resolved	Controlled	Uncontrolled
		Medication Allergies (specify)			
		Severe Food Allergies (specify)			
		Autoimmune Disorder (Lupus, RA, Psoriasis) or other (please list)			
		HIV or AIDS			
		Hypertension ☐ or Hypotension ☐			
		Heart Condition (past or present) (specify)			
		Blood Clotting Disorder (specify)			
		Diabetes Type 1 ☐ Type 2 ☐			
		Herpes Simplex Cold sores/Fever Blisters ☐ Genital ☐			
		Staph Infection (specify)			
		Asthma (specify) Child ☐ Adult ☐ Both ☐			
		Hepatitis (circle those that apply) A B C D			
		Kidney Disease (specify)			
		Skin Cancer (specify type, location, & date)			
		Cancer (specify type & date)			
		Thyroid Disease hyper ☐ hypo ☐ other ☐			
		Shingles (specify location and last episode)			
		Seizures (specify last episode/frequency)			
		Wounds that stay brown after healing			
		Keloid Disorder (scars that grow beyond the border of the wound)			
		Slow Wound Healing			
		Sensitive Skin (specify)			
		Electrical Implants (Pacemaker, etc. Please specify)			
		Metal Implants (Not including dental fillings) (specify location)			
		Previous complications with Cosmetic Laser Treatments or Injections? (Specify)			
		Neuromuscular or Neurological Disorder (Specify)			
		Connective Tissue Disease (Ehlers Danios, etc.) (Specify)			
		Anaphylaxis (specify)			
		Tattoos/Permanent Make-Up (specify location)			
		WOMEN: Currently Pregnant or Breastfeeding			
		WOMEN: Abnormal Menstrual Cycle / POS			
		WOMEN: Trying to become pregnant			
		ANY OTHER HEALTH CONDITION NOT LISTED ABOVE (specify)			

****The above health questionnaire is accurate. I agree to disclose all changes to my health at future visits.**

Print Name: _____ **Signature:** _____ **Date:** _____

Date of Birth: _____ PA/NP/MD Signature: _____ Date: _____