



Patient Health Information

Name: Last _____ First _____ MI _____

Address: _____ City: _____ State _____ Zip _____

Birth date: ____/____/____ Age: _____ SSN: _____ - _____ - _____ Sex: Male / Female

Phone: _____ Email: _____

Employer: _____ Phone: _____ Occupation: _____

Emergency contact: _____ Phone: _____

Have you been seen at Aegis Women’s Healthcare in the past 3 years? _____

How did you hear about us? _____

Do you smoke? Yes ____ No ____ Do you use tanning beds? Yes ____ No ____ How often? _____

Please put a check mark next to the procedures about which you would like to receive more information:

- ___ Acne Treatment ___ Brown Spots
___ Skin Care Regimen ___ Sun Damage
___ Enhanced Skin Rejuvenation ___ Broken Capillaries
___ Collagen Augmentation ___ Spider Veins/Leg Veins
___ Wrinkles ___ Hair Reduction
___ Skin Toning or Pore Size Reduction ___ Shaving bumps/Ingrown hair
___ Facial Redness

Please put a check mark next to a past or current medical condition:

- ___ Lupus or other auto-immune deficiency ___ Herpes simplex or fever blisters
___ Rheumatoid Arthritis “Gold” Therapy ___ Diabetes
___ Currently Pregnant ___ Light sensitive Epilepsy
___ Bleeding abnormalities ___ Scars that turn white or brown
___ Treatment with Accutane® in the last year ___ Dark spots after pregnancy, melasma
___ Treatment with Tetracycline® or Zithromax® ___ HIV
in the last month ___ Hepatitis
___ Keloid or very thick scarring ___ Waxing/Plucking/Electrolysis within last four weeks
___ Psoriasis or Vitiligo ___ Transplant Anti-Rejection Drugs
___ Pulmonary embolism/blood clot ___ Chemical Peels, Dermabrasion, Laser Resurfacing or Face Lift
___ Leg ulcer or Phlebitis ___ Tattoos/permanent make-up
___ Blood thinning medication ___ Polycystic ovarian syndrome (PCOS)
___ Coumadin/anti-clotting agents ___ Implants (Location: _____)
___ Delayed wound healing ___ Collagen injection (Location: _____)
___ Skin cancer

Allergies: Yes ____ No ____ Please indicate any reactions to medication, drugs, latex, and the type of reaction, (i.e. hives, shock, breathing disorders). _____

Please list any medication, herbal supplements, aspirin, or over the counter medications that you are currently taking: _____

Patient Signature: _____ Date: _____