## Columbus Medical Aesthetics

# MEDICAL REGISTRATION FORM

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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| Today’s Date:  | PRIMARY CARE PHYSICIAN:  |

basic medical INFORMATION

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| Patient’s last name:  | First:  | Date of Birth:  |  | Marital status:  |

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| Do you have a pacemaker, defibrillator or any implanted medical plates? | Do you have any drug, food or environmental allergies? (please list with type of reaction) | Are you currently pregnant, lactating or trying to become pregnant?  | Please list all current daily medications (prescribed/homeopathic):  | Sex: |
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Please list all surgeries:

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| --- | --- | --- |
| Preferred Pharmacy Name:  | Pharmacy Address: | Pharmacy Phone no.: |
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| List all Major Medical Conditions: | Circle all that apply: keloids scars, acne, rosacea, eczema, cold sores, fever blisters, skin cancer, pigment issues (hyper or hypo), MRSA, easily bruised, psoriasis | Are you currently taking anything that may affect your ability to heal? If so, please list the medication:  |
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| --- | --- | --- |
| I currently have a skin care regimen at home:  |  | YES |
|  |  | NO |

If yes, please list your protocol: Activity INFORMATIONPlease answer all questions

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| How easily do you tan and how often are you in the sun/tanning bed: | Do you wear sunscreen on a daily basis, if so, what SPF?: | Have you ever had any aesthetic procedures done; if yes, please list: | What major changes would you like to see in your skin (what are your goals): |
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| Do you smoke? |  | Do you consume alcohol regularly? |  |
| Occupation: | Employer: | Employer address: | Employer phone no.: |
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Please describe your sleeping habits (number of hours a night):

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| --- | --- | --- |
| How much water do you drink a day: | How many meals do you have a day: | Please list any special diets you follow: |
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Do you exercise regularly, if so, how often:

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| Please list any other information you would like your provider to know: |
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Who is your dermatologist: Date of your last visit: IN CASE OF EMERGENCY

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| --- | --- | --- |
| Name of local friend or relative (not living at same address): | Relationship to patient: | Phone no.: |
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Signature:  |
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