## Columbus Medical Aesthetics

# MEDICAL REGISTRATION FORM

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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| |  |  | | --- | --- | | Today’s Date: | PRIMARY CARE PHYSICIAN: |  basic medical INFORMATION  |  |  |  |  |  | | --- | --- | --- | --- | --- | | Patient’s last name: | First: | Date of Birth: |  | Marital status: |  |  |  |  |  |  | | --- | --- | --- | --- | --- | | 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: | |  |  |  |  |  |   Please list all surgeries:   |  |  |  | | --- | --- | --- | | Preferred Pharmacy Name: | Pharmacy Address: | Pharmacy Phone no.: | |  |  |  | | 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: | |  |  |  |  |  |  |  | | --- | --- | --- | | I currently have a skin care regimen at home: |  | YES | |  |  | NO |   If yes, please list your protocol: Activity INFORMATIONPlease answer all questions  |  |  |  |  | | --- | --- | --- | --- | | 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): | |  |  |  |  | | Do you smoke? |  | Do you consume alcohol regularly? |  | | Occupation: | Employer: | Employer address: | Employer phone no.: | |  |  |  |  |   Please describe your sleeping habits (number of hours a night):   |  |  |  | | --- | --- | --- | | How much water do you drink a day: | How many meals do you have a day: | Please list any special diets you follow: | |  |  |  |   Do you exercise regularly, if so, how often:   |  | | --- | | Please list any other information you would like your provider to know: | |  |   Who is your dermatologist: Date of your last visit: IN CASE OF EMERGENCY  |  |  |  | | --- | --- | --- | | Name of local friend or relative (not living at same address): | Relationship to patient: | Phone no.: | |  |  |  |   Signature: |
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