ENTOffice.org, PLLC Medical History Form For Cosmetic Injection

Today's Date: __/__/___

****** Please complete ALL the information; if Not Applicable, please write "N/A" ******

Patient's Name: _____Date of Birth: __/__/___

Person Completing Form and how you are related to the patient: _____

(if you are the patient, write "self")

When was your first visit with ENTOffice.org? _____

Regular (primary) Doctor: _____

How did you hear about ENTOffice.org? _____

If another person referred you, what is his or her name? _____

What areas of your face are you interested in enhancing today? _____

Medicines:

Does the patient take any medicines? **Yes** □ **No** □

If "Yes", what do they take and when do they take them?

Name and strength	Do you take it every day?	How many times a day?
	Yes □ **No** □	
	Yes □ **No** □	
	Yes □ **No** □	

Does the patient have allergies to any medicines? **Yes** □ **No** □

If "Yes", what are they? _____

Explain what happens when the patient has a bad reaction to medicine:

_____

Tobacco

Does the patient use tobacco? **Yes** □ **No** □ What type?_____ How much?_____ When did you start?_____If the patient quit, how long ago? _____

Alcohol

Does the patient drink alcohol? **Yes** □ **No** □ If yes, how much? _____

Reproductive

Are you pregnant? Yes □ No □ Not sure □

Are you nursing? Yes □ No □

Method of Birth Control:_____

Personal Medical History:

1. Do you have an active inflammatory process (skin eruptions such as cysts, pimples, rashes or hives)?

Yes □ No □

2. Have you recently had an infection of any kind (sinus infection, UTI)?

Yes □ No □

3. Have you recently had the flu or other viral illness?

Yes □ No □

4. Do you have a history of oral herpes and if so when was your last breakout?

Yes □ No □

5. Do you have an autoimmune disease (lupus, rheumatoid arthritis, MS)?

Yes □ No □

6. Do you have a history of allergies, and have you ever had an anaphylactic reaction?

Yes □ No □

7. Have you had surgical or nonsurgical cosmetic procedures before?

Yes □ No □

8. Have you had any dental procedures or visits to the oral hygienist in the last month? Yes □ No □

Do you have any planned in the next month? Yes □ No □

9. Have you had any medical procedures or immunizations in the past month?

Yes □ No □

Do you have any planned in the next month? Yes □ No □

10. Are you taking any blood thinners (aspirin, nonsteroidal anti-inflammatory drugs, and warfarin) or do you consume blood-thinning products (eg, salmon oil, vitamin E, ginkgo biloba, red wine, dark chocolate, grapefruit)?

Yes □ No □

11. Have you ever seen a medical provider for your skin?

Yes □ No □ If yes, explain: _____

12. Have you ever had Botox injected before?

Yes □ No □ If yes, last injection date: _____

13. Have you ever had filler injected before?

Yes □ No □ If yes, last injection date: _____

Medical History— Please check "Yes" if the patient has EVER had any of these problems

	Yes	No		Yes	No
Autoimmune Disease	□	□	COPD (lung disease)	□	□
Kidney Disease	□	□	Diabetes	□	□
Bleeding Disorders	□	□	Heart disease	□	□
Thyroid disorders	□	□	High blood pressure	□	□
High cholesterol	□	□	Asthma	□	□
Pneumonia	□	□	Other past medical history:		
Tuberculosis	□	□	_____		
Cancers	□	□			

Are you (the patient) having any of these problems RIGHT NOW? If yes, what?

_____

Please tell us all the operations the patient has had (and when):

What: (ex: tonsils out)	**When:** (ex: 2007 or 10 years ago)

Is there anything else we should know?

_____

ENTOffice.org, PLLC Patient Registration Form Today's Date: ___/__/____

Patient's Name: ___Date of Birth: __/__/___
Parent/Guardian (if minor): _____ Relationship: _____
Address: _____
City: _____ State: _____ Zip Code: _____
Phone: ( ) _____ ☐ Ok to leave a message?
Mobile: ( ) _____☐ OK to text appointment reminders?
Email: _____ ☐ OK to contact via email?
Sex: Male □ Female □ Other □ Pronoun (optional): _____
Social Security Number: _____-___-_____

Are you Hispanic or Latino? **Yes** □ **No** □

Race:
□American Indian/Alaskan Native
□Asian
□Black/African American
□Native Hawaiian/Pacific Islander
□White/Caucasian

Education/Employment:

If you (the patient) are a student: School Name: _____ Grade: _____

Patient or Parent/ Guardian: Employer: _____