Lakes COSMETIC INSTITUTE

Patient Name: _____ Age: _____ DOB: _____

Mailing Address: _____ Phone: _____

Occupation: _____ Reason for visit: _____

Preferred Method of Contact (Circle one): US Mail Phone Email Text Message

May we contact you via email? Yes/No: _____ Email Address: _____

Would you like to receive text specials? Yes/No: _____ If yes, please provide cell # _____

How did you hear about us? (Circle one): Newspaper TV Radio Friend/Family Other: _____

Drug Allergies: _____

Conditions:		**Medical History:**	**Current Medications:**
Heart Disorder:	Yes/No	_____	_____
Cancer:	Yes/No	_____	_____
Diabetes:	Yes/No	_____	_____
Thyroid Disorder:	Yes/No	_____	_____
Lung Disorder:	Yes/No	_____	_____
Intestinal Disorder:	Yes/No	_____	_____
Skin Disorder:	Yes/No	_____	_____
Clotting Disorder:	Yes/No	_____	_____
Psychiatric Disorder:	Yes/No	_____	_____
Liver Disorder:	Yes/No	_____	_____
Neurologic Disorder:	Yes/No	_____	_____
Kidney Disorder:	Yes/No	_____	_____

Family History:	**General Surgical History:**	**Cosmetic Surgical History:**
Malignant Hyperthermia: Yes/No	_____	_____
Bleeding Disorder: Yes/No	_____	_____

Social History:

Do you smoke? Yes/No If yes, how many cigarettes per day: _____ History of Fever Blisters/Herpes? Yes/No: _____

Do you have latex allergies? Yes/No: _____

Do you drink alcohol? Yes/No: _____ If yes, how much/how often: _____

PATIENT SIGNATURE: _____ DATE: _____