New Patient

Name (print): ____ Date: ______________

Date of Birth: ___________ Occupation: __________________ Cell phone: __________________

Home (address, city, state, zip): ____

Email: ________________________________ Interested in offers and **new treatments**? Yes ☐ No ☐

Emergency Contact (name, phone, relation): ____

How did you hear about us (name)? ____

Reason for visit: ____

Are you worried about how you look? ☐ No ☐ Yes

How much time do you usually spend thinking about how you look? (Add up all the time per day)
☐ Less than 1 hour a day ☐ 1-3 hours a day ☐ More than 3 hours a day

Medications / Vitamins / Supplements / Substances:

Do you take aspirin, ibuprofen, herbal medication, or other **blood thinners**? ☐ Yes ☐ No

Illnesses (include past major illnesses):

Surgery / Procedures (include dates):

Height: ______ **Weight**: ______ **Gender at Birth**: Female Male Intersex **Gender Identity**: Female Male Non-Binary

Allergies to any medications, foods, or environmental factors? ☐ Yes ☐ No List all allergies:

____

Do you **smoke**? ☐ Yes ☐ No Packs per day ___ How many years? ___ If quit, when? _____

Do you drink **alcoholic** beverages? ☐ Yes ☐ No Amount ________

Are you **pregnant** or **nursing**? ☐ Yes ☐ No ☐ N/A

Do you or any blood relatives have a **bleeding** problem? ☐ Yes ☐ No

Medical problems that you or any family members have or have had?

____

☐ I acknowledge I have read **Notice of Privacy Practices**

Signature: ____

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