MIN S. AHN MD|FACS
THE AESTHETIC WELLNESS CENTER

Patient Information	
Patient Name:	Date of birth:
Street Address:	Gender: ☐Male ☐Female
City, State, Zip:	Weight: Height:
Home telephone:	Marital Status:
Alternate phone number: Work / Cell	Occupation:
May we leave messages on your voicemail? ☐ Yes ☐ No ***(note: the representative from our office will never leave any personal health information on an answering machine) What is the best way to contact you? (Cell Phone, Home Phone, Work Phone, or Email)	
Name of Legally Responsible Representative:	
Relationship to Patient: ***A copy of Power of Attorney must be on file, if one exists.	
Street Address:	
City, State, Zip:	Telephone:

Referral/Contact Information	
E-Mail Address:	☐ Check here if you **do not** wish to receive e-mail notifications or mailings

How did you hear about us?
Please check all that apply.

☐ Friend (Name:_____)
☐ Salon: _____
☐ Physician: _____
☐ Other: _____
☐ Seminar:_____)
☐ Facebook
☐ Google/Yahoo/Bing Search Engine
☐Fraxel.com/Botoxcosmetic.com/sculptraaesthetic.com
☐ Awcenter.com

Patient Medical History

*** please use back of form if more space is needed ***

Medications:
Please complete attached Universal Medication Form.

Have you ever had surgery? ☐ Yes ☐ No

Date	Operation/Procedure	Date	Operation/Procedure

Have you ever been exposed to, or tested positive for, MRSA (Methicillin-Resistant Staphylococcus Aureus)**?**
☐ Yes ☐ No If yes, please describe: _____
_____
_____

Allergies (include medication, food, environment, insect bites, dye, others) ☐ **None**

What are you allergic to?	What happens when you are exposed?

Have you ever had swelling, itching, or hives after being exposed to latex products? ☐ Yes ☐ No
If yes, please describe:

Do you take any of the following?
☐ Aspirin ☐ Ibuprofen ☐ Motrin
☐ Advil ☐ Ginkgo Biloba ☐ Supplemental Shakes
☐ Vitamin E ☐ Fish Oil ☐ Multivitamin
☐ **None**

Do you smoke tobacco products? ☐ Yes ☐ No
If yes, _____ packs/day for _____years?
Have you ever smoked tobacco products? ☐ Yes ☐ No
If yes, _____ packs/day for _____years?
Do you engage in recreational drug activity? ☐ Yes ☐ No
What is your alcohol intake? _____ drinks/week

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Patient Name: _____ DOB: _____

Have you or do you currently experience any of the
Following medical problems or issues?

	Yes	No
Nasal:		
Sinus Disease	☐	☐
Nasal Blockage	☐	☐
Excessive Snoring	☐	☐
Cardiovascular:		
High Blood Pressure	☐	☐
Coronary Artery Disease	☐	☐
Heart Attack	☐	☐
Shortness of Breath	☐	☐
Fainting Spells	☐	☐
Respiratory		
Asthma	☐	☐
Chronic Lung Disease	☐	☐
Pneumonia	☐	☐
Wheezing	☐	☐
Allergies	☐	☐
Excessive coughing	☐	☐
Sleep Apnea	☐	☐
Neurological:		
Stroke	☐	☐
Seizures	☐	☐
Depression/Anxiety	☐	☐
Headaches	☐	☐

	Yes	No
Eyes:		
Glaucoma	☐	☐
Dry Eyes	☐	☐
Cataracts	☐	☐
Do you wear contact lenses?	☐	☐
Hematologic:		
Anemia	☐	☐
Excessive Bleeding	☐	☐
Easy Bruising	☐	☐
Skin:		
Fever/Herpes Blisters	☐	☐
Keloid Scarring	☐	☐
Thick/Abnormal Scarring	☐	☐
Delayed Healing	☐	☐
Vitiligo (Pigment Loss)	☐	☐
Endocrine:		
Diabetes	☐	☐
Thyroid Disease	☐	☐
History of Steroid Use	☐	☐
Chance of Pregnancy: ☐ n/a	☐	☐

Other Medical Conditions:

_____
_____
_____
_____

Physician's Initials _____ Date_____

Primary Care Physician's Name: _____ Address: _____
Telephone Number: _____

I By signing this form I assure the information provided is complete and accurate to the best of my knowledge. If any of the above information should change, I understand that it is my responsibility to inform the organization of such changes. I have received a copy/am aware of the **Patient Bill of Rights**; as required by law and have had an opportunity to receive assistance in understanding and exercising these rights. I have received a copy/am aware of this office's **Notice of Privacy Practices**, including the **Private Health Information (PHI)** designated at the time of visit. I have received information on/am aware of the Infection Control measures utilized by this organization. I have received a copy/am aware of the **Practice Disclosure (about our Practice, including the Grievance process)** and am comfortable with that information. I also understand this practice's position on **Do Not Resuscitate (DNR) and Living Wills** and that this practice does not honor these directives.

_____ _____ _____

Signature of Patient or Responsible Party Printed Name Date