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:<br>Work / Cell | Occupation: |
| May we leave messages on your voicemail? ☐ Yes ☐ No<br>***(note: the representative from our office will never leave any personal health information on an answering machine)<br>What is the best way to contact you? (Cell Phone, Home Phone, Work Phone, or Email) | |
| Name of Legally Responsible Representative: | |
| Relationship to Patient:<br>***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