Physician's Plan
WEIGHT LOSS+WELLNESS

PATIENT INFORMATION

Name_____ Birth date_____ Age_____ ❒ Male ❒ Female

Mailing Address_____
(Street) (City) (State) (Zip)

Street Address (if different)_____
(Street) (City) (State) (Zip)

Home Phone: _____ **Email Address:** _____

Mobile Phone: _____

Work Phone: _____

All information will be kept confidential and only used to contact you. Phone support is important. We would also like to email reminders and our monthly newsletter.

Place of Employment_____ Occupation_____

How did you hear about Physician's Plan? ❒ Internet ❒ Television ❒ Facebook ❒ Email
❒ Friend/Family Member _____
❒ Other _____

HEALTH HISTORY

❒ Yes ❒ No Are you presently under a Physician's care?
❒ Yes ❒ No Are you currently taking any medications? Please list _____
❒ Yes ❒ No Do you smoke?
❒ Yes ❒ No Do you develop cold sores/ fever blisters?
❒ Yes ❒ No Are you slow to heal from injury or medical procedure?
❒ Yes ❒ No Have you ever had Herpes Simplex? If yes, have you ever been treated with Denavir® (Penciclovir), Zovirax® (Acyclivor) or Abreva? ❒ Yes ❒ No
❒ Yes ❒ No Are you being treated for Hepatitis?

Female clients only:

❒ Yes ❒ No Are you on hormone replacement therapy?
❒ Yes ❒ No Are you presently taking birth control pills?
❒ Yes ❒ No Are you pregnant or nursing?

Please check all that apply:

❒ Accutane
❒ Acne
❒ Allergies
❒ Arthritis
❒ Artificial Implants
❒ Asthma
❒ Birth Control
❒ Blood Disorder
❒ Blood Thinner
❒ Cancer
❒ Contact Lenses
❒ Depression
❒ Diabetes
❒ Distended Capillaries
❒ Eczema
❒ Fever Blisters
❒ Heart Condition
❒ Hepatitis
❒ High/Low Blood Pressure
❒ Hyper/Hypo pigmentation
❒ Hyper/Hypo thyroid
❒ Insomnia
❒ Lupus
❒ Metal plates/pins
❒ Nail Disorders
❒ Pacemaker
❒ Phlebitis
❒ Plastic Surgery
❒ Psoriasis
❒ Retin-A ™
❒ Seborrhea
❒ Sensitivities
❒ Skin Cancer
❒ Surgeries
❒ Underweight
❒ Overweight
❒ Claustrophobia
❒ HIV/AIDS
❒ Scleroderma

Allergies:

Have you ever had an allergic reaction or sensitivities to any of the following?

❒ Yes	❒ No	Aspirin or Salicylates	❒ Yes	❒ No	Ingredients in skincare products
❒ Yes	❒ No	Milk	❒ Yes	❒ No	Fish, marine or iodine allergies
❒ Yes	❒ No	Apples	❒ Yes	❒ No	Latex
❒ Yes	❒ No	Citrus	❒ Yes	❒ No	Vitamin A
❒ Yes	❒ No	Grapes	❒ Yes	❒ No	Perfumes
❒ Yes	❒ No	Retinols	❒ Yes	❒ No	Hydroquinone
❒ Yes	❒ No	Nuts	❒ Yes	❒ No	Alcohol based products

If Yes to any of the above **OR** if you have any other allergies or sensitivities **NOT** listed above, please explain: _____

_____

_____

SKIN CARE HISTORY

❒ Yes ❒ No Have you seen a Dermatologist in the past year?

If yes, Physician Name:_____ Date of Last Visit: _____

Please check if you are presently using or have used in the past any of the following:

❒ Benzoyl Peroxide (BP)	❒ Sulfur	❒ Glycolic Acid (AHA)	❒ Vitamin A
❒ Lactic Acid (AHA)	❒ Vitamin C	❒ Resorcinol	❒ Hydrocortisone (HC)
❒ Salicylic Acid (BHA)	❒ Hydroquinone (HQ)		

Please check if you are presently experiencing or have experienced any of the following:

❒ Acne Lesion (cysts)	❒ Pustules (inflamed)	❒ Uneven texture
❒ Acne Scars	❒ Ingrown Hairs	❒ Visible Capillaries
❒ Black Heads	❒ Hyperpigmentation	❒ Dilated Pores
❒ Whiteheads	❒ Sun Damage	❒ Fine lines/Wrinkles
❒ Dilated Capillaries	❒ Papules (inflamed)	❒ Lack of Elasticity

Please check all that apply regarding your skin type:

❒ Normal	❒ Dry	❒ Very Sensitive	❒ Acne
❒ Mature	❒ Oily	❒ Rosacea	❒ Sensitive/Breakout

Have you had any of the following in the last <u>14 days</u>?

❒ Facial Cosmetic Surgery	❒ Chemical Peel/Exfoliation	❒ Botox Injection
❒ Extractions	❒ Collagen Injections	❒ Permanent Cosmetics
❒ Fillers	❒ Waxing	❒ Light Treatments
❒ Laser Hair Removal	❒ Laser Resurfacing	❒ Hair Treatments (perm, color, highlights, etc.)
❒ Microdermabrasion	❒ Microneedling	