Danvers FAMILY DOCTORS P.C.

Patient Demographic Form

Patient Name: _____ SS#: _____ DOB: _____

Address: _____ Mobile Phone: _____

City, State Zip _____ Email: _____

Sex: M F

May we leave messages for you on your mobile phone? YES NO

May we contact you through e-mail? YES NO

Emergency Contact Information

Name: _____ Relationship: _____

May er discuss your medical records with this person? YES NO Mobile Phone: _____

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Medical History Form

Name: _____Date:_____

Age:_____ **Male**:____ **Female**:____

How did you hear about our practice?_____

Have you had in the past or do you currently have? :

Pigmentation issues, hyper or hypo pigmentation	Y	N	Heart Disease	Y	N		
Diabetes	Y	N	Irregular Pulse			Y	N
Gold Therapy	Y	N	Fainting Spells			Y	N
Seizure Disorder (Epilepsy)	Y	N	Asthma			Y	N
High Blood Pressure	Y	N	Keloid Formation			Y	N
Polycystic Ovarian Syndrome	Y	N	Rosacea			Y	N
Irregular Menses	Y	N	Lupus			Y	N
Thyroid Disorder	Y	N	Hepatitis			Y	N
History of Herpes Simplex infections/fever blisters	Y	N	Chemotherapy			Y	N
Acne	Y	N	Skin Cancer			Y	N
Are you Photosensitive	Y	N	Have you ever used **Retin-A**?			Y	N
Have you ever had a chemical peel or microderm?	Y	N	Have you ever taken **Acutane**?			Y	N
Do you have any Tattoos or permanent makeup?	Y	N	Cancer	Y	N		
Have you ever had any laser treatments?	Y	N	Other medical issues or illnesses			Y	N
			Radiation therapy.			Y	N

Medications: (Please list any medications you are currently taking including herbal supplements and vitamins.)

_____

What topical medications or creams are you currently using? Retin-A, Others?

_____

Are you taking mood altering or anti-depression medication? ___ Y ___ N

Are you under the care of a physician? ___Y ___ N If yes, why? _____.

Drug Allergies: (Please list any known drug allergies) :_____

Have you had any recent tanning, sun exposure or used tanning creams that changed the color of you skin? Y N

Do you use sunscreen? ____Y ____N What SPF? _____ Do you scar easily? ____Y_____N Do you heal quickly? ____Y_____N

Have you used any of the following hair removal methods in the past six weeks?

Shaving ____Waxing ___ Electrolysis ____ Tweezing_____ Threading _____ Depilatories _____

Please mark area(s) of interest:

Hair Removal _____ Brown Spots_____ Wrinkles _____ Rosacea _____ Facial Veins _____ Sagging Skin ____

What treatments would you like to discuss today?_____

For our female patients: Are you pregnant or trying to become pregnant? _____Yes _____No

I certify that the preceding medical, personal and skin history statements are true and correct. I am aware that it is my responsibility to inform the staff at Danvers Family Doctors, P.C. of my current medical or health conditions and to update this history with any changes that my occur. A current medical history is essential for the caregiver to execute appropriate treatment procedures.

Signature:_____ Date:_____