Face By Fisher - New Patient Form

Emergency Contact Information

First Name	Last Name
Street Address	
Street Address 2	
City	State
Zip Code	
Phone Number	
Alternate Phone	
Social Security Number:	
Date of Birth	
Sex	
Select your desired appointment date	Are you interested in a skin care consultation after your visit ?

Employer Information

Occupation	Employer
Work Phone Number:	
Email Address	

Parent/Guardian/Spouse Information

Please enter your parent/guardian/spouse information here, if applicable.
Full Name
Street Address
Street Address 2
Phone
Alternate Phone
Birth Date
Relationship to You

Insurance Information

Primary Insurance	
Secondary Insurance (if applicable)	
Subscribers Name (First)	
Last Name:	Subscribers Date of Birth

Other Information

How did you find out about us?
If by Physician please tell us who
Who is your Primary Care Physician?
If you are a student please tell us what school you attend

Emergency Contact Information

Emergency Contact (preferably someone not living with you)	
Name	
Phone Number	Alternate Phone
Relationship to You	
Briefly explain the reason for your visit:	

Medications and Allergies

Current Medications and Dosages

Medications and Allergies

Please list all medications you are currently on
Are you allergic to any medications?
If so, please list the medications
Reactions to meds, if any
Are you allergic to latex?
Other Allergies

Patient's Surgeries & Past Medical History

Check as many as apply

Surgeries

- ❑ Back
- ❑ Breast
- ❑ Cardiac
- ❑ Ear
- ❑ Eye
- ❑ Gastric Bypass
- ❑ Nasal
- ❑ Plastic
- ❑ Sinus
- ❑ Thyroidectomy
- ❑ Tonsillectomy
- ❑ Tympanoplasty

other surgeries please list:

Medical History

- ❑ Cancer
- ❑ Diabetes
- ❑ Downs Syndrome
- ❑ Hepatitis
- ❑ High Blood Pressure/Stroke
- ❑ Jaundice
- ❑ Lung Disease
- ❑ Seizures/Epilepsy
- ❑ Sleep Apnea
- ❑ Speech/Hearing Problems
- ❑ Stomach Problems (Ulcer/Reflux)

Please list any other medical history information we should know about

Review of Symptoms

Check all that apply

Cardio Respiratory

- ❑ Chest Pain
- ❑ Fainting Spells
- ❑ Foot & Ankle Swelling
- ❑ Palpitations
- ❑ Shortness of Breath
- ❑ Wheezing

Genitourinary

- ❑ Blood in Urine
- ❑ Infection
- ❑ Menopause
- ❑ Menstrual Problems
- ❑ Painful Urination
- ❑ Stones

Gastrointestinal

- ❑ Appetite
- ❑ Change in Bowel Habits
- ❑ Nausea/Vomiting
- ❑ Pain
- ❑ Rectal Bleeding
- ❑ Spitting Blood

Nervous System

- ❑ Convulsions
- ❑ Paralysis

Bone & Joint

- ❑ Arthritis
- ❑ Bone Problems

Please list any other problems you might have that weren't previously listed

Family History

Family History

- ❑ Asthma
- ❑ Bleeding Disorder
- ❑ Cancer
- ❑ Diabetes
- ❑ Tuberculosis

Please list any family history that is not listed above

Smoking and Alcohol History

Smoking History

Smoking

If yes, how many packs per day?

If you've quit smoking, what year did you quit?

Alcohol History

Do you drink?

How much do you drink?

Do you, or have you ever used recreational drugs?

If so, describe

Surgical History

Have you or a familiy memeber ever had a problem with

- ❑ Anesthesia
- ❑ Malignant Hyperthermia

If you checked either of the above, please describe the problem(s) here:

Should you require surgery, are you willing to receive a blood transfusion if necessary?

Check all that you have taken recently

- ❑ Anti-inflammatory
- ❑ Aspirin
- ❑ Vitamin E
- ❑ Dietary Supplements
- ❑ Echinacea
- ❑ Ephedra (Ma-Huang)
- ❑ Feverfew
- ❑ Garlic
- ❑ Ginko
- ❑ Ginseng
- ❑ Goldensel
- ❑ Kava-Kava
- ❑ Licorice
- ❑ St. John's Wort
- ❑ Valerian