



Skinspirations Center for Cosmetic Enhancement
Patient Registration Form
Feather Sound Corporate Center II, Suite #555
13577 Feather Sound Dr., Clearwater, FL 33762
Phone 727-571-1923

Please print out this form, completely fill it out and bring it with you to your first appointment.

Last name _____ First Name _____ Age _____

Birth date: ___/___/_____ Email: _____

Address: _____
Street City State Zip

Home phone: _____ Work phone: _____

Cell phone: _____ Occupation: _____ Gender: Female Male

Employer: _____ Employer address: _____

Street City State Zip

Who can we thank for referring you to our practice? _____
Or did you hear about us from our
 website/internet flyer/brochure yellow pages ad other _____

Please list below anyone who may receive medical information about you. Please include anyone who may answer your phone with whom we may leave a message for you such as a spouse, child or parent.

Names: _____

May we leave a message for you on your answering machine, identifying ourselves as "Skinspirations"? Yes No

May we email personal medical information to you? Yes No
If not, is there another address you would prefer we use for correspondence with you?

Street City State Zip

Would you like to receive office updates and newsletters via email? Yes No

In case of emergency, contact: _____
Name Phone



Skinspirations Center for Cosmetic Enhancement

Patient Medical History

**Feather Sound Corporate Center II, Suite #555
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Name: _____ **Date of Birth:** _____ **Today's Date:** _____

Allergies: _____ **My allergic reaction was:** _____

Medications (including supplements, herbs, aspirin, etc) : I do not take any medications

Past Medical History: (Mark any of the following you have been diagnosed with or treated for)

- | | | |
|-----------------------------------------------------|----------------------------------------------------|-------------------------------------------------|
| <input type="checkbox"/> Acne | <input type="checkbox"/> Migraines | <input type="checkbox"/> Mitral valve prolapse |
| <input type="checkbox"/> Bleeding disorder | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Keloids |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Lupus | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Heart disease | <input type="checkbox"/> Alcohol or drug addiction | <input type="checkbox"/> Anxiety/panic disorder |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Kidney disease | <input type="checkbox"/> Thyroid disease |
| <input type="checkbox"/> Diabetes __oral medication | <input type="checkbox"/> Herpes/ cold sores | <input type="checkbox"/> Suicidal thoughts |
| <input type="checkbox"/> __insulin | <input type="checkbox"/> Seizures | <input type="checkbox"/> Thyroid disease |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Liver disease | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Myasthenia Gravis | <input type="checkbox"/> Chronic Pain | <input type="checkbox"/> HIV |

Have you ever filed a lawsuit or complaint with a state-regulating agency against a physician? Yes No

Past Surgical History:

- | | | |
|------------------------------------------------------|----------------------------------------------|---------------------------------------|
| <input type="checkbox"/> Gallbladder/cholecystectomy | <input type="checkbox"/> Facelift | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Hysterectomy | <input type="checkbox"/> Breast augmentation | _____ |
| <input type="checkbox"/> Appendectomy | <input type="checkbox"/> Blepharoplasty | _____ |

Past Cosmetic Procedure History:

- Peels: __TCA __Glycolic __Phenol __Obagi __Lactic acid __Other (type?) _____
- Botox
- Collagen or other fillers, areas treated: _____
- Laser hair removal, area treated: _____
- IPL spot, vessel reduction, area treated _____
- Sclerotherapy and laser vein removal
- Laser skin resurfacing, Type: _____ Area treated: _____
- Thermage
- Mesotherapy, areas treated and when: _____
- Featherlift
- Cosmetic Micropigmentation
- Other: _____

Social History: Do you smoke? Yes No

Do you drink alcohol? Yes No