CLEAR CHOICE
AESTHETICS

COMPREHENSIVE PATIENT INTAKE FORM

Today's Date: _____

Name: _____ DOB: _____

Address: _____

Phone Number: _____ email: _____

By which of these ways can we contact you?
☐ Phone ☐ Text ☐ email

Can we leave voicemails for you?
☐ Yes ☐ No

Do you want someone other than yourself to be able to receive your health information?
☐ Yes ☐ No
If yes, please answer the following:
Name of the person: _____
Their relationship to you: _____
Check the type of information they can receive:
☐ All medical information
☐ Limited to (please specify): _____

Emergency Contact
Name: _____
relationship to you: _____
Phone Number: _____

Who is your primary-care Doctor?
Name: _____
Phone Number: _____

Your pharmacy
name: _____
Pharmacy phone (not the store phone: _____

When was the last time you had vaccinated? _____

Allergies

Do you have any allergies?
☐ Yes ☐ No
If yes, please list them below

_____ _____
_____ _____
_____ _____

Past Medical History

Which of these have you ever had (check all that apply):

- ☐ Any heart conditions
- ☐ Any Conditions or diseases of the blood vessels
- ☐ Cholesterol problems
- ☐ Blood pressure (high or low)
- ☐ Any Neurologic conditions—diseases of the brain, spinal cord or the nerves
- ☐ Chronic headaches
- ☐ Chronic pain
- ☐ Any lung or breathing problems
- ☐ Any Digestive problems—Problems chewing, swallowing, stomach, gut, or bowels
- ☐ Any Liver problems
- ☐ Any Kidney problems
- ☐ Diabetes or pre-diabetes
- ☐ Any thyroid problems
- ☐ Anxiety, Depression, Bipolar disorder
- ☐ Any other psychiatric issues or diagnoses
- ☐ Any problems conceiving
- ☐ any problems with your cycles, with conceiving or pregnancies
- ☐ Any types of Cancer
- ☐ Any blood disorder
- ☐ Ever received blood or other blood products
- ☐ Any types of Cancer
- ☐ Any disease or condition of the bones or joints
- ☐ Any disease or condition of muscles and tendons
- ☐ Any disease or condition of skins

How many times have you been hospitalized before? _____

Have you ever spent a night in the ICU?

☐ Yes ☐ No

What specialists have you ever seen?

_____
_____

Which of these surgeries or procedures have you ever had (check all that apply)?

- ☐ Any surgeries on the head or neck
- ☐ Back surgeries
- ☐ Surgeries on hip or pelvis
- ☐ Surgeries on the throat
- ☐ Surgeries on the chest
- ☐ Surgeries on the Abdomen
- ☐ Surgeries on the urinary or reproductive organs
- ☐ Any Cosmetic surgeries
- ☐ Heart (including bypasses, valve replacements, pacemakrs, cardiac catheterization)
- ☐ Blood transfusions
- ☐ any other surgeries/procedures not mentioned:

_____
_____

Have you ever had a severe trauma?

☐ Yes ☐ No

Medications (list all current medications and dosages if you know them):

_____
_____
_____
_____

Social History

Have you ever used any tobacco or nicotine-containing products (smoking, vaping, chewing)?

☐ Yes ☐ No

If yes…

What quantity or how many packs per day? _____

For how many years altogether? _____

Other than occasional social drinking, have you ever used alcohol?

☐ Yes ☐ No

If yes…

How many days a week do you drink? _____ days/week

How much do you drink in a day? _____

What is your drink of choice? _____

What age did you start drinking? _____

Do you now, or have you ever, used recreational drugs or prescription meds for recreation?

☐ Yes ☐ No

List the drugs you have tried

_____

_____

If you do use drugs, what is your drug of choice? _____

How frequently do you use? _____

What age did you start? _____

Family History

Which of these have any family member ever had (check all that apply)? Write which family member in the space provided:

☐ Any heart conditions _____

☐ Any Neurologic conditions _____

☐ Any respiraotry problems _____

☐ Any Digestive problems _____

☐ Any Liver problems _____

☐ Any Kidney problems _____

☐ Diabetes or pre-diabetes _____

☐ Any thyroid problems _____

☐ Psychiatric Problems _____

☐ Any addiction issues _____

☐ Any other psychiatric issues or diagnoses

☐ Any types of Cancer

System Review

Check all symptoms that apply to you:

☐ Change in your level of energy

☐ Excess energy

☐ Change in appetite:

☐ increased ☐ decreased

☐ Sleep problems (too much, too little)

☐ Snoring, waking up tired, partner says you sometimes stop breathing when asleep
☐ Recent change in weight
how much have you lost? _____ or gained? _____
In how much time? _____
☐ Problems with sex
☐ For women, problems with conceiving or with past pregnancies
☐ For women: is it possible that you might be pregnant now
☐ Headaches, Dizziness
☐ Feeling Foggy in the head
☐ Changes in memory or concentration
☐ New onset clumsiness, recent falls, poor coordination
☐ Change in vision
☐ Change in hearing
☐ Change in the sense of smell or taste
☐ Sores in the mouth
☐ Rash on the skin
☐ Losing teeth or have gum problems
☐ problem with chewing food
☐ problem with swallowing food
☐ problem with food digestion, heart burn, acid reflux
☐ Nausea or vomiting
☐ Diarrhea
☐ Constipation
☐ Abdominal pain, swelling, bloating, or other discomfort
☐ Neck pain
☐ Yellowing of the skin
☐ Change in stool color, shape, or consistency
☐ Chest pain or pressure
☐ Palpitations
☐ Shortness of breath
☐ Cough
☐ Difficulty breathing when lying flat
☐ Problems urinating or holding the urine
☐ Changes in the urine itself
☐ Skin changes (color, dryness, lumps, bumps, bruises, rashes…)
☐ hair loss (or excessive hair)
☐ Any change in sensation
☐ weakness in the face or limbs
☐ Pain, tenderness, weakness, twitching in any muscles
☐ Joint pain, swelling, redness, limited movement
☐ Heat or cold intolerance
☐ Change in the pattern of perspiration (like new excess sweating…)
☐ Problems with excess bleeding
☐ Females: Change in your monthly cycles
☐ Change in breasts (men too)
☐ change in mood-- Anxious or depressed
☐ Change in social interactions

_____ _____
Signature Date

_____
Print name