CENTER FOR
REGENERATIVE HEALTH

Patient Intake Form

First Name: ________________________________ Last Name: ______________________________

Address: ____

City: ____________________________ State: ________________ Zip Code: _________________

Telephone: Home _________________ Work _________________ Cell ______________________

Occupation:___________________________ How did you hear about us:_______________________

Date of Birth: _____________________ Age:___________ Sex: Female _____ Male _____

Family Doctor: __________________________________ Phone: _____________________

Pharmacy: ______________________________________ Phone: _____________________

Emergency Contact: ______________________________ Phone: ___________________

Medical History

Please answer all of the following questions	**NO**	**YES**
1. Do you have **ANY** current or chronic medical illnesses?	☐	☐
Heart Disease (Heart Attack, Palpitations, etc):	☐	☐
(If YES, explain) ____		
Neurological Disease (Seizures, Epilepsy, Photosensitivity etc):	☐	☐
(If YES, explain) ____		
Lung Disease (COPD, Asthma, etc):	☐	☐
(If YES, explain) ____		
Liver/Kidney Disease (Cirrhosis, Hepatitis, etc):	☐	☐
(If YES, explain) ____		
Cancer (Leukemia, Lymphoma, Melanoma, etc):	☐	☐
(If YES, explain) ____		

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	NO	YES
Digestive Problems (IBS, Diarrhea, etc):	☐	☐

(If YES, explain) ____

Hypertension/Vascular disease (DVT, etc):	☐	☐

(If YES, explain) ____

Trauma (serious car accidents, injuries, etc):	☐	☐

(If YES, explain) ____

Infectious Disease (Tuberculosis, STDs, etc):	☐	☐

(If YES, explain) ____

Immunosuppression (HIV, AIDS, etc):	☐	☐

(If YES, explain) ____

Endocrine Disorder (Thyroid, Diabetes, etc):	☐	☐

(If YES, explain) ____

Mental Illness (Depression, Suicide, Bipolar, etc):	☐	☐

(If YES, explain) ____

Autoimmune Conditions:	☐	☐

(If YES, explain) ____

2. Do you have **ANY** current or chronic skin conditions? ☐ ☐

Also disclose any history of vitiligo, eczema, melasma, psoriasis, allergic dermatitis, any diseases affecting collagen including Ehlers-Danlos syndrome, scleroderma, skin cancer, or any other skin condition.

Please List: ____

____

3. Are you currently under a doctor's care? If so, for what reason? ☐ ☐

____

Medical History, Continued

		NO	YES
4.	Do you take/use **ANY** medications (prescriptions and nonprescriptions), vitamins, herbal or natural supplements, on a regular or daily basis?	☐	☐

Please List: ____

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5. Are there any topical products (both medical and non-medical) that you use on your skin on a regular or daily basis?

If so, please list:____

		NO	YES
6.	Do you take/use ANY systemic/oral steroids (e.g., prednisone, dexamethasone)?	☐	☐
7.	Do you have **ANY** allergies to medications, foods, latex or other substances? Please List: ______________________	☐	☐
8.	(For women) are you or could you be pregnant?	☐	☐
9.	(For women) are menstrual periods regular, or have you ever been diagnosed with Polycystic Ovarian Disorder?	☐	☐
10.	Do you have a history of herpes I or II in the area to be treated?	☐	☐
11.	Do you have a history of keloid scarring or hypertrophic scar formation?	☐	☐
12.	Do you have a history of light induced seizures?	☐	☐
13.	Do you have any open sores or lesions?	☐	☐
14.	Do you have any history of radiation therapy in the area to be treated?	☐	☐
15.	In the last six (6) months, have you used any of the following: anticoagulants or blood-thinning medications; photosensitizing medications; or anti-inflammatory or blood thinning medications? Please List product name and date last used: ______________________	☐	☐
16.	In the last three (3) months, have you used any of the following products: glycolic acid or otheralphahydroxy or betahydroxyacid acid products; exfoliating or resurfacing products or treatments? Please List product name and date last used: ______________________	☐	☐
17.	Do you have or have you ever had any permanent make-up, tattoos, implants, or fillers,including, but not limited to, collagen, autologous fat, Restylane®, etc.? If yes, please list locations on or in the body and dates: ______________________	☐	☐
18.	Do you have or have you ever had any Botulinums, such as Botox® or Dysport®? If yes, please list locations on or in the body and dates: ______________________	☐	☐

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19. Have you taken Accutane® (or products containing isotretinoin) in the last 12 months? ☐ ☐
20. Have you taken Tretinoin (like Retin-A®, Renova®) in the last 6 months? ☐ ☐
21. Have you had any unprotected sun exposure, used tanning creams (including sunless tanning lotions) or tanning beds or lamps in the last 4-6 weeks? ☐ ☐

    Last Sun Exposure (tanning/ outdoor activity):____

22. How does your skin react when exposed to the sun? (please circle only ONE of these six choices below)

    a) Always Burns & Never Tans
    b) Burns Easily & Tans Minimally
    c) Sometimes Burns & Slowly Tans
    d) Burns Minimally & Usually Tans
    e) Rarely Burns & Tans Well
    f) Never Burns & Always Tans

23. Which body area/areas or condition would you like treated?_________________________

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24. Are there any other services that you are interested in?

☐ Bioidentical Hormone Replacement Therapy

☐ Vitamin Infusion Therapy

☐ Body Sculpting

☐ Laser Facial Services

☐ Laser Hair Removal

☐ Tattoo Removal

Signature: ____Date: ________________________