DOCTOR: Joseph C. Galitzin, MD

DATE: _____

PATIENT LAST NAME: _____ FIRST NAME: _____

ADDRESS: _____ CITY: _____ STATE: ____ ZIP: _____

SEX M F MARITAL STATUS S M D BIRTHDATE: _____

E-MAIL: _____ EMPLOYER: _____

CELL PHONE: _____

WORK PHONE: _____HOME PHONE: _____

EMERGENCY CONTACT: _____RELATIONSHIP: _____

EMERGENCY PHONE: _____

PRIMARY PHYSICIAN: _____PHARMACY: _____

HOW DID YOU HEAR OF US*?* _____

**I would like to receive text messages about our practice. These automated text messages can include special promotions, information about new services or team members. I understand that I will always have the ability to opt-out if I decide that I no longer want to receive texts from this practice. YES NO

REASON FOR VISIT: _____

WOULD YOU BE INTERESTED IN INFORMATION REGARDING COSMETIC PROCEDURES SUCH AS: (please circle all that apply) *Hair Reduction, sunspot removal, anti-aging products, Botox, Juvederm, Voluma, Volbella, facial veins, peels, facials, Cool Sculpting, Tattoo removal, Ultherapy, Micro-needling with Radio Frequency, Hand rejuvenation, co2 Resurfacing, Plasma Skin Pen, BBL, Halo or Artas Robotic Hair Restoration.*

Medical History

Do you have any allergies? ____Y ____ N
If yes, to what? _____What was your reaction? _____

What medications are you on? Please include vitamins, herbs, topicals, patches taken on a daily basis.

_____ _____
_____ _____
_____ _____

Have you had in the past or currently have:

____ Diabetes
____ Hypertension
____ Seizure disorder
____Polycystic Ovary Disease
____ Irregular heartbeat
____ Fainting spells
____ Heart Attack
____ Heart Disease
____ Thyroid Disease
____ Asthma
____ Herpes Simplex virus
____ Lupus
____ Rosacea
____ Keloid scarring
____ Stroke

For Women

Are you or could you be pregnant?	____ Y	____ N
Are your periods regular?	____ Y	____ N
Do you have a history of herpes {Cold Sores}?	____ Y	____ N
Have you taken Accutane in the last 6 months	____ Y	____ N
Do you have permanent make up or tattoos in the area to be treated?	____ Y	____ N
Do you have any implants?	____ Y	____ N
Have you used tanning beds in the last 4 wks.?	____ Y	____ N
Have you used tanning creams in the last 4 wks.?	____ Y	____ N
Have you had unprotected sun exposure in the last 4 weeks?	____ Y	____ N
Do you use sunscreen? SPF _____	____ Y	____ N

Natural Hair Color? ____ Blonde ____ Red ____ Light Brown ____Dark Brown ___ Black ___ Gray

SURGERY / HOSPITALIZATIONS

1. Have you ever had surgery? Yes No
2. Please list approximate dates and reasons for any surgery or other conditions that required hospitalization: (a separate list may be provided)

Dates: _____ Reason for stay:

_____
_____
_____

Social History

Smoking Do you currently use tobacco products? Yes No

If yes: Cigarettes Cigars/Pipes Smokeless

How many packs per day? _____

If no: Have you used tobacco in the past? Yes No Year Quit: _____

Alcohol

a. How many days per week do you drink beer, wine, or other alcoholic beverages? _____
b. How many drinks do you have in average week? _____

Caffeine

How much caffeinated coffee or caffeine containing beverages do you drink per day? _____

Exercise

a. Do you exercise regularly? Yes No Type: _____

b. On average, how many days per week do you exercise? _____
C. For how many minutes, on an average day? _____

General Health Status. Please rate your health: Excellent Good Fair Poor

Patient Signature: _____