



*Welcomes you...*

**Please provide the following information so we may better serve you.**

Your legal name \_\_\_\_\_ Today's Date \_\_\_\_\_  
(First) (Middle) (Last)

What name should we call you? \_\_\_\_\_ Birth Date \_\_\_\_\_

Are you: male or female Are you: single, married or other \_\_\_\_\_

Home address: \_\_\_\_\_ City \_\_\_\_\_ State & zip \_\_\_\_\_

Home phone \_\_\_\_\_ cell phone \_\_\_\_\_ work phone \_\_\_\_\_  
Please circle the above phone number where we should contact you.

Do you permit us to leave a message for you at the above number? Yes or No

Email \_\_\_\_\_ employer: \_\_\_\_\_ occupation \_\_\_\_\_

Spouse's name \_\_\_\_\_ Do you authorize us to discuss your  
information with your spouse if they call? Yes or No

Please list an emergency contact who does not live with you \_\_\_\_\_

Relationship \_\_\_\_\_ home phone \_\_\_\_\_ cell phone \_\_\_\_\_

**Please indicate which concerns you might want to improve:**

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> fine lines around eyes    | <input type="checkbox"/> lines around lips        | <input type="checkbox"/> forehead creases   |
| <input type="checkbox"/> drooping corners of mouth | <input type="checkbox"/> laser hair reduction     | <input type="checkbox"/> nasal wolf lines   |
| <input type="checkbox"/> laser skin resurfacing    | <input type="checkbox"/> removal of skin lesions  | <input type="checkbox"/> scar revision      |
| <input type="checkbox"/> laser micropeel           | <input type="checkbox"/> skin care regimen        | <input type="checkbox"/> laser vein therapy |
| <input type="checkbox"/> age or sun spot removal   | <input type="checkbox"/> mole or skin tag removal | <input type="checkbox"/> laser photo facial |
| <input type="checkbox"/> hyperbaric oxygen therapy | <input type="checkbox"/> tired-looking eyes       | <input type="checkbox"/> skinny lips        |
| <input type="checkbox"/> desire to quit smoking    | <input type="checkbox"/> uncontrolled appetite    | <input type="checkbox"/> weight gain        |



**Please check all medical conditions or therapies that apply to you:**

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> pregnancy / recent childbirth | <input type="checkbox"/> hormone imbalance           | <input type="checkbox"/> epilepsy      |
| <input type="checkbox"/> high blood pressure           | <input type="checkbox"/> varicose veins              | <input type="checkbox"/> diabetes      |
| <input type="checkbox"/> currently smoking             | <input type="checkbox"/> facial surgery              | <input type="checkbox"/> eczema        |
| <input type="checkbox"/> migraine headaches            | <input type="checkbox"/> cosmetic implants           | <input type="checkbox"/> asthma        |
| <input type="checkbox"/> chemotherapy                  | <input type="checkbox"/> thyroid abnormalities       | <input type="checkbox"/> acne          |
| <input type="checkbox"/> metal bone pins or plate      | <input type="checkbox"/> hormone replacement therapy | <input type="checkbox"/> cancer        |
| <input type="checkbox"/> panic attacks / anxiety       | <input type="checkbox"/> permanent cosmetics         | <input type="checkbox"/> rosacea       |
| <input type="checkbox"/> brain or neurological surgery | <input type="checkbox"/> herpes zoster               | <input type="checkbox"/> HIV positive  |
| <input type="checkbox"/> heart condition               | <input type="checkbox"/> unwanted hair growth        | <input type="checkbox"/> age/sun spots |
| <input type="checkbox"/> keloid or unusual scars       | <input type="checkbox"/> Accutane or gold therapy    | <input type="checkbox"/> chest pain    |
| <input type="checkbox"/> hysterectomy /oophorectomy    | <input type="checkbox"/> hot flashes / night sweats  | <input type="checkbox"/> seborrhea     |
| <input type="checkbox"/> excessive bleeding            | <input type="checkbox"/> psychological counseling    | <input type="checkbox"/> sun tanning   |
| <input type="checkbox"/> unintentional weight gain     | <input type="checkbox"/> unintentional weight loss   | <input type="checkbox"/> depression    |

Please list any other health concerns or illnesses not listed above: \_\_\_\_\_

Please list any surgeries or injuries you had in the last 12 months: \_\_\_\_\_

Please list any medications you currently take, including hormone injections or topical creams you may use \_\_\_\_\_

Please list any food, cosmetic or drug allergies \_\_\_\_\_

What would you like us to help you improve today? \_\_\_\_\_

**For laser therapies, please provide the following dates:**

Last use of Retin A \_\_\_\_\_ last menstrual period (females only) \_\_\_\_\_

Last taken Accutane or gold therapy \_\_\_\_\_ Glycolic treatment \_\_\_\_\_

Last microdermabrasion \_\_\_\_\_ last laser therapy \_\_\_\_\_

Last use of bleaching creams, hair removal creams or waxing to the area to be treated today \_\_\_\_\_ last sun tan or tanning bed use \_\_\_\_\_

Last Botox treatment \_\_\_\_\_ Last filler injections \_\_\_\_\_

Please circle any of the following if you have taken in the last two weeks:  
St. John's Wort, Bufferin, Advil, Ibuprofen, Nuprin, vitamin E, fish oil, aspirin



**For hormone therapies**, please circle any of the following symptoms that you experience: anxiety, fatigue, insomnia, headaches, mood swings, erectile dysfunction, hair loss, organ removal, hot flashes, night sweats, irregular menses, irritability, vaginal dryness, breast tenderness, dry skin or hair, aggressiveness, memory loss, thinning eyebrows, fluid retention, decreased libido, memory loss, weight gain, weight loss  
What other hormone therapies have you tried? \_\_\_\_\_

When did you last have your hormone levels tested? \_\_\_\_\_

If you are interested in **weight loss therapy**, please indicate:

Have you ever been diagnosed with diabetes? Yes  No  If yes, when? \_\_\_\_\_

Please list any heart conditions you may have \_\_\_\_\_

or please check  I have no known heart conditions

If you have you had any history of cancer, please describe \_\_\_\_\_

or please check  I have no history of any type of cancer.

What is your desired weight? \_\_\_\_\_ What is your current weight? \_\_\_\_\_

Please indicate how you learned of our services.....

yellow pages  newspaper  friend \_\_\_\_\_

TV / radio ad  brochure / flyer  website \_\_\_\_\_

physician  office poster  other \_\_\_\_\_

### **Authorization**

I certify that this information provided is complete and accurate to the best of my knowledge. I understand that payment for all services rendered at Ford Center for Anti-Aging and Pain Management are due at the time that services are provided. My information will remain confidential and will only be discussed with any names I wrote above. I will submit all changes in writing. I authorize Dennis C. Ford, MD and his representatives to provide therapeutic and cosmetic services. I hereby permit Dennis C. Ford, MD or any assistant that he may designate to take photographs for diagnostic and evaluation purposes. I further authorize him to use such photographs for teaching purposes, to illustrate scientific papers, books, lectures, medical research, public education, pamphlets or via website. These photographs will remain the physician's property. I understand that in any such use, I will not be identified by name.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date