Registration & Health History

Patient Name_____DOB_____Date_____

Address_____Apt. #_____

City_____State_____Zip_____

Cell Phone_____ Email_____

Gender: Male_____ Female_____ Occupation_____

Emergency contact_____ phone _____

Have you been a patient of OSC Aesthetic Services or Oral Surgeons of Charlotte before?____

How did you hear about us?_____

Are you under the care of a physician?_____ For what condition? _____

Name & Phone of Physician_____

Date of last skin cancer screening_____ Date of last physical_____

List all medications you are taking (prescription & OTC) _____

_____

List any drug or contact allergies_____

Do you smoke?_____ If yes, how many per day for how many years_____

Do you drink alcohol?_____ How much/how often_____

Have you ever had any of the following?

___Asthma
___Autoimmune disorder
___Clotting disorder
___Easily bruise
___Heart attack
___Heart failure
___HIV
___Keloids
___Lung disease
___MVP
___Shortness of Breath
___Thyroid disorder
___Cancer please list type_____

___Arthritis
___Blood disorder
___Diabetes
___Excessive scarring
___Heart valve disease
___Hepatitis ___A ___B ___C
___Irregular Heart Beat
___Kidney disease
___Multiple Sclerosis
___Migraines
___Seizures

___Anemia
___Chest pain
___Depression
___Excessive bleeding
___Heart valve replacement
___High Blood Pressure
___Intestinal Problems
___Liver disease
___Muscular Dystrophy
___Rheumatic Fever
___Stroke

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Please list all surgeries or hospitalizations with dates: _____

_____

_____

Have you ever had any cosmetic procedures in the past? Please list with dates: _____

_____

_____

Do you have any tattoos or “permanent” make up near any areas you would like treated?_____

If so, please list _____

_____

To the best of my knowledge, the information provided above is true and accurate.

Patient Signature_____ Date_____

Provider Signature_____ Date_____