Agapé
MEDICAL SPA & WEIGHT LOSS

PATIENT DEMOGRAPHIC
(Please Print Legibly)

Patient Name:_____DOB:_____M / F

Home Phone:_____Work Phone:_____Cell Phone: _____

Mailing Address:_____City:_____State:_____Zip:_____

Preferred Email: _____

Married:_____Single:_____Widowed: _____Divorced: _____Legally Separated: _____

Emergency Contact Name:_____Relationship_____

Emergency Contact Phone#: _____

Are you Pregnant? Y / N Planning a Pregnancy? Y / N Are you breastfeeding? Y / N Do you live alone? Y/ N

Primary Care Physician name & Address: _____

Name and Address of Pharmacy: _____

I understand and agree that I am ultimately responsible for the balance on my account for any professional services rendered. I, the undersigned/guardian have read the HIPPA guidelines and understand the training, credentialing, and experience of all practitioners in the clinic.

_____

Patient Responsible Party Relationship Date Signed

History and Intake Form

Past Medical History: (**Please check off all that apply**)

- o Anxiety
- o Arthritis
- o Asthma
- o Atrial Fibrillation
- o BPH
- o Bone Marrow Transplant
- o Breast Cancer
- o Colon Cancer
- o COPD
- o Coronary Artery Disease
- o Depression
- o Diabetes
- o End Stage Renal Disease
- o GERD
- o Hearing Loss
- o Hepatitis
- o High Blood Pressure
- o HIV/AIDS
- o High Cholesterol
- o Over Active Thyroid
- o Under Active Thyroid
- o Leukemia
- o Lung Cancer
- o Lymphoma
- o Prostate Cancer
- o Radiation Treatment
- o Seizures
- o Stroke
- o **None**

Other _____

Past Surgical History: (**Please check off all that apply**)

- o Appendix Removed
- o Bladder Removed
- o Mastectomy (Right, Left, Bilateral)
- o Lumpectomy (Right, Left, Bilateral)
- o Breast Biopsy (Right, Left, Bilateral)
- o Breast Reduction
- o Breast Implants
- o Colectomy: Colon Cancer
- o Colectomy: Diverticulitis
- o Colectomy: IBD
- o Gallbladder Removed
- o Coronary Artery Bypass
- o PTCA
- o Mechanical Valve Replacement
- o Biological Valve Replacement
- o Heart Transplant
- o Joint Replacement, Knee (Right, Left, Bilateral)
- o Joint Replacement, Hip (Right, Left, Bilateral)
- o Joint Replacement within last 2 Years
- o Kidney Biopsy
- o Kidney Removed (Right, Left)
- o Kidney Stone Removal
- o Kidney Transplant
- o Ovaries Removed: Endometriosis
- o Ovaries Removed: Ovarian Cyst
- o Ovaries Removed: Ovarian Cancer
- o Prostate Removed: Prostate Cancer
- o Prostate Biopsy
- o TURP
- o Skin Biopsy
- o Basal Cell Cancer Surgery
- o Squamous Cell Cancer Surgery
- o Melanoma Surgery
- o Spleen Removed
- o Testicles Removed (Right, Left, Bilat)
- o Hysterectomy: Fibroids
- o Hysterectomy: Uterine Cancer
- o **NONE**

Other: _____

SKIN DISEASE HISTORY: (**Please check off all that apply**)

- o Acne
- o Actinic Keratosis
- o Asthma
- o Basal Cell Skin Cancer
- o Blistering Sunburns
- o Dry Skin
- o Eczema
- o Flaking or Itchy Scalp
- o Hay Fever/ Allergies
- o Melanoma
- o Poison Ivy
- o Precancerous Moles
- o Psoriasis
- o Squamous Cell Skin Cancer
- o **NONE**

Other: _____

Do you wear Sunscreen? Yes No If yes, what SPF? _____
Do you tan in a tanning salon? Yes No

Do you have a family history of Melanoma? Yes No

If yes, which relative(s)? _____

MEDICATIONS: (Please list ALL Medications)

_____
_____
_____

ALLERGIES: (Please list ALL Allergies & Reactions)

_____
_____
_____

SOCIAL HISTORY: (Please circle all that apply)

Cigarette Smoking:
Currently Smokes
Has smoked in the past
Never smoked
Former Smoker

Alcohol Use:
None
Less than 1 drink per day
1-2 drinks per day
3 or more drinks per day

OCCUPATION & WORKPLACE: _____

How often do you exercise_____**What is your caffeine use** _____

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I have received information regarding the providers of care in this organization, a copy of the Patient's Bill of Rights and Responsibilities and information regarding the grievance process. I have been presented with a copy of the notice of Privacy Practices detailing how my health information may be used and disclosed as permitted under federal and state law, and outlining my rights regarding health information.

Patient of Responsible Party Signature **Date**