Lafferty
Family Care
With You. For Life.

PATIENT INFORMATION AND INTAKE FORM 2019

Date: _____

Name: _____

First Middle Last

DOB: _____ Age: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Home Telephone: _____

Cell phone: _____ Ok to leave to email or leave a message? Y / N

Email: _____

Occupation: _____

How did you hear about us?: _____

Ethnic Background: _____

Marital Status (please circle): Married Single Divorced Widow Living w/Significant Other

EMERGENCY CONTACT INFORMATION

In case of emergency please contact: _____

Relationship to you: _____

Contact Number: _____

CURRENT MEDICAL HISTORY

Please State the reason(s) for your visit and describe any symptoms you are experiencing:

_____

_____

Hospitalizations/ Surgeries (including tonsils, gallbladder, appendix, cosmetic):

Procedure	Year

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Medications/ Supplements

Medication/ Supplement	Reason for taking	Date Began	Dose

Have you had any allergic reaction to the following?

Local Anesthetics (ex: Lidocaine)	Y	N
Penicillin or other antibiotics	Y	N
Sulfa Drugs	Y	N
Latex	Y	N
Sedatives	Y	N
Iodine	Y	N
Aspirin	Y	N
Drugs	Y	N
Food	Y	N
Other	Y	N

If yes, what happens? _____

Please list any relevant family history:

_____

_____

List Yes (Y), No (N), or Past (P) regarding use of the following:

Steroids: Y N P If yes, for what condition and dosages? _____

Smoking: Y N P If yes, how much per day? _____

***Smoking in any amount compromises the healing process and may negatively affect the outcome of your treatment.**

Analgesics: Y N P Caffeine: Y N P Ounces per day if YES: _____

Alcohol: Y N P If yes, How much per week? _____

Recreational Drugs? Y N P

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Have you ever had or are you currently experiencing any of the following?

Acne	Y	N	Lupus/ SLE	Y	N
Anorexia	Y	N	Lymph Node Disorder	Y	N
Anemia	Y	N	Migraines	Y	N
Asthma	Y	N	Multiple Sclerosis	Y	N
Bleeding Tendency	Y	N	Pacemaker/Electrical Implants	Y	N
Blood disorder	Y	N	Poor wound healing	Y	N
Bruising Tendency	Y	N	Respiratory Disease	Y	N
Cancer-Active	Y	N	Rheumatoid Arthritis	Y	N
Cancer- Remission	Y	N	Raynauds	Y	N
Cardiac Disorder	Y	N	Scleroderma	Y	N
Cold Sores	Y	N	Shingles	Y	N
Current Cold/ Flu	Y	N	Sjogrens	Y	N
Diabetes	Y	N	Skin rash- Currently	Y	N
Epilepsy/ Seizures	Y	N	Staph Infection/ MRSA	Y	N
Hepatitis Type_____	Y	N	Stroke	Y	N
High Blood Pressure	Y	N	Thyroid Disorder	Y	N
High Cholesterol	Y	N	Please list any other conditions:		
HIV	Y	N	_____		
Infection Currently	Y	N	_____		
Kidney Disease	Y	N	_____		
Leukopenia	Y	N	_____		
Liver Disease	Y	N			
Low Blood Pressure	Y	N			

If You answered YES, to any of the above questions, please state how this medical condition is being managed. Name of Physician, Name of Medications, other Treatments, etc.

_____
_____
_____
_____

I attest that the above information is accurate to my knowledge and will alert LFC if any information about my health changes.

Client Signature: _____ Date: _____

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NO	YES	Do You currently, or have you ever had any of the following conditions?	Resolved	Controlled	Uncontrolled
		Medication Allergies (specify)			
		Severe Food Allergies (specify)			
		Autoimmune Disorder (Lupus, RA, Psoriasis) or other (please list)			
		HIV or AIDS			
		Currently using Retinol, Retin-A, or other prescription topical?			
		Hypertension [ ] or Hypotension [ ]			
		Heart Condition (past or present) (specify)			
		Blood Clotting Disorder (specify)			
		Diabetes Type 1 [ ] Type 2 [ ]			
		Herpes Simplex Cold Sores/ Fever Blisters [ ] Genitals [ ]			
		Staph Infection (specify)			
		Asthma (specify) Child [ ] Adult [ ] Both [ ]			
		Lung Disorder (Emphysema, Chronic Bronchitis, Other)			
		Hepatitis (Circle those that apply) A B C D			
		Kidney Disease (specify)			
		Skin Cancer **(specify type, location, & date)**			
		Cancer **(specify type & date)**			
		Thyroid Disorder hyper [ ] hypo [ ] other [ ]			
		Shingles (specify location & last episode)			
		Seizures (specify last episode/ frequency)			
		Wounds that Stay Brown after Healing			
		Keloid Disorder (scars that grow beyond the border of the wound)			
		Slow wound healing			
		Sensitive Skin (specify)			
		Electrical Implants (Pacemaker, etc. Please specify)			
		Metal Implants (*not including dental fillings*) (Specify location)			
		Previous complications with cosmetic laser treatments or injections? (specify)			
		Neuromuscular or Neurological Disorder (specify)			
		Connective Tissue Disease (Ehlers Danlos, etc) (specify)			
		Anaphylaxis (specify)			
		Tattoos/ Permanent Make-Up (specify location)			
		WOMEN: Currently pregnant or breastfeeding?			
		WOMEN: Abnormal Menstrual Cycle/ POS			
		WOMEN: Trying to become pregnant			
		ANY OTHER HEALTH CONDITION NOT LISTED ABOVE (specify)			

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No	Yes	Do you take any prescription or over the counter medications? (Include herbal supplements) Please list (REQUIRED):

**The above health questionnaire is accurate. I agree to disclose all changes to my health at future visits.

Print Name: _____Signature: _____Date:_____

Date of Birth: _____

MD Signature: _____ Date:_____