Medical Intake Form

TODAY'S DATE: _____

Name: _____ DOB: _____ Age: _____

Address: _____

City: _____ State: _____ Zip: _____

Preferred Phone: _____ Email address: _____

Gender: ☐ Female ☐ Male Height: _____ Weight: _____

Emergency Contact: (name, phone # and relationship): _____

Are you willing to receive marketing and newsletter information via email from time to time? ☐ Yes ☐ No

How did you hear about us: Please circle one or more:

Ad/Flyer Friend Magazine Event Physician

If a friend or ad, can you be more specific? _____

Doctors Name	Specialty	Phone	Last visit
	Primary Care		

Are you aware of allergies you may have to foods, drugs or mediations? ☐ Yes ☐ No

If so: ☐ Dairy ☐ Seafood ☐ Gluten ☐ Other _____

If allergic, what reaction do you have? _____

Medications	Last Used	Medications	Last Used	Medications	Last Used
Coumadin		Prednisone		Cialis, Viagra, Levitra	
Advil, Motrin, Ibuprofen		Topical Hydrocortisone		Hormone Therapy	
Aspirin		Corticosteroids		Prednisone	
Accutane		Retin A (Tretinoin)		Hydrocortisone	
Glycolic Acid		Renova		Facial Waxing	
Retinol		Corticosteroids			

Medical History: (Do you have any of these problems?)

Problem	When Dx'd	Treatment	Problem	When Dx'd	Treatment
Heart Disease			Drug or alcohol abuse		
High Blood Pressure			Autoimmune disease		

Blood Clotting problems			Herpes (oral or genital)		
Bleeding Problems			Hepatitis (acute or chronic)		
Arrhythmia or murmur			HIV		
Cancer			HPV		
Chemotherapy			Psoriasis		
Skin Cancer			Steroid Therapy		
Warfarin Use (Coumadin)			Myasthenia gravis		
Diabetes			Lambert-Eaton		
Peyronie's disease			Other – please list		
Thyroid disease					

Current Prescriptions: use separate sheet if necessary

Medication Name	Dose	Frequency	Reason	Date Started	Doctor Prescribing

General Concerns:

Check any areas of interest to you, even those you are not here for today:

- ○ Skin rejuvenation
- ○ Non-surgical Hair Regrowth
- ○ Improved sexual function
- ○ Non-surgical treatment for urinary incontinence
- ○ Regenerative treatment for pain (joint, tendon, muscular)
- ○ Arm and/or Hand, Rejuvenation
- ○ Face, Neck and/or Chest, Rejuvenation
- ○ Scar Therapy

Other: _____

General Information

Do you exercise?	_____ Yes _____ No
Do you smoke?	_____ Yes _____ No

How would you rate the condition of your healthy? □ Excellent □ Good □ Satisfactory □ Fair □ Poor
How would you rate your current nutritional status? □ Excellent □ Good □ Satisfactory □ Fair □ Poor
How would you rate your current diet? □ Excellent □ Good □ Satisfactory □ Fair □ Poor
Your current stress management skills are? □ Excellent □ Good □ Satisfactory □ Fair □ Poor
Are you taking prescription meds past or present for the following? Yes No High Blood Pressure? Elevated Cholesterol? Depression/anxiety? Anemia/low iron? Thyroid disease (low or high)? Additional info you want Dr. Hamlett to know regarding medications:

Have you ever been diagnosed with?	Yes	No
Hormonal abnormalities?		
Eating disorder?		
Menstrual cycle abnormalities?		
Recent pregnancy?		
Menopause?		
Allergic response or adverse reaction?		
Sexual dysfunction?		
Urinary incontinence?		

Aesthetic Concerns:

What are your skin care concerns? _____

- ○ Acne
- ○ Pigmentation
- ○ Redness
- ○ Sun Damage
- ○ Skin Laxity
- ○ Wrinkles
- ○ Skin Texture
- ○ Rosacea
- ○ Oily / Dry
- ○ Stretch Marks
- ○ Scars
- ○ Facial Veins

Have you used Accutane in the past 6 months?	☐ Yes	☐ No
Do you use Retin A (Tretinoin)? Do you have a history of breakouts?	☐ Yes	☐ No
Have you had Botox?	☐ Yes	☐ No
Have you have Fillers?	☐ Yes	☐ No
Would you like to know more about PRP for skin rejuvenation?	☐ Yes	☐ No
Would you like to know more about PRP Facelift and PRP Facial?	☐ Yes	☐ No

Hair Concerns:

When did you first begin to notice your hair change?
What brand of shampoo and conditioner do you use most often?
What are you experiencing? ☐ Thinning ☐ Shedding ☐ Receding ☐ Breakage ☐ Oily Scalp ☐ Dry, flaking
Is your hair loss: ☐ Just starting ☐ Slowing Down ☐ Accelerating ☐Basically done ☐ No sure
Hair loss affects me: ☐ When getting ready in the AM ☐ When meeting new people ☐ When seeing old friend ☐ On windy days ☐ When I wear a hat ☐ When swimming ☐ At work or school ☐ When I see myself in photos or videos ☐ When people comment ☐ In my overall social life ☐ My overall self esteem
Do you regularly use any form of camouflage? ☐ Yes ☐ No
Do you routinely wear a hairpiece or wig? ☐ Yes ☐ No
Have you tried any of the following? ☐ Propecia/Proscar ☐Rogaine/Minoxidil ☐Avodart/Dutasteride ☐ Laser Cap or Hood ☐ Vitamins/Supplements ☐ Special Shampoo ☐ Laser Comb ☐ Hair transplant surgery
Are you currently taking Propecia or Proscar? ☐ Yes ☐ No
Do you feel Propecia or Proscar has been effective? ☐ Yes ☐ No ☐ Unsure

Are you currently using Rogaine or Minoxidil? □ Yes □ No If so: □2% □5% □Twice a day □ Once a day □ Weekly □ Less Frequently
Do you feel Rogaine or Minoxidil has been effective? □ Yes □ No □ Unsure
Have you ever had a genetic test for hair loss? □ Yes □ No If yes what outcome?
Have you ever had a hair transplant? □ Yes □ No If yes, by whom?

Type	Risk Factors	Yes	No
	Do you or your blood relatives have thin hair or hair loss? Is your hair part-line widening? Is your hairline receding or do you have noticeably less hair coverage and more scalp showing? Have you worn or do you currently wear a hair piece, hair systems or extensions?	□ □ □ □ □ □ □ □	□ □ □ □ □ □ □ □
	DO you routinely color your hair? Do you routinely chemically perm or straighten your hair? Do you routinely use a protein shake containing creatine? Do you drink alcoholic beverages? Are you a smoker present or past of cigarettes and/or cigars?	□ □ □ □ □ □ □ □ □	□ □ □ □ □ □ □ □ □

Female Sexual Function:					
Over the Past 30 days 0. Never 1. Rarely 2. Occasionally 3. Frequently 4. Always How often do you feel...	0	1	2	3	4
Distressed about your sex life?					
Unhappy about your sexual relationship?					
Guilty about sexual difficulties?					
Frustrated by your sexual problems?					

Stressed about sex?					
Inferior because of sexual problems?					
Worried about sex?					
Sexually inadequate?					
Regrets about your sexuality?					
Embarrassed about sexual problems?					
Dissatisfied with your sex life?					
Angry about your sex life?					
Bothered by low sexual desire?					

Female Urinary Incontinence:						
Over the Past 6 months: 0. Never 1. Rarely 2. Occasionally 3. Frequently 4. Often 5. Always Do you leak urine (even small drops), wet yourself, or wet your pads or undergarments ….	0	1	2	3	4	5
When you cough of sneeze?						
When you bend down or lift something up?						
When you walk quickly, jog or exercise?						
While you are undressing in order to use the toilet?						
Do you get such a strong and uncomfortable need to urinate that you leak urine (even small drops) or wet yourself before reaching the toilet?						
Do you have to rush to the bathroom because you get a sudden strong need to urinate?						

Is there anything else you'd like us to know?