

Wendy A. Epstein, M.D., F.A.A.D.

NAME: \_\_\_\_\_ DATE: \_\_\_\_\_

DATE OF BIRTH [mm/dd/yyyy]: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

E-MAIL: \_\_\_\_\_

HOW DID YOU LEARN ABOUT DR. EPSTEIN? \_\_\_\_\_

HOME TEL: \_\_\_\_\_ CELL: \_\_\_\_\_ WORK: \_\_\_\_\_

PHARMACY NAME & TELEPHONE: \_\_\_\_\_

EMERGENCY CONTACT: \_\_\_\_\_ TELEPHONE: \_\_\_\_\_

WHAT ARE YOUR MAIN CONCERNS THAT BROUGHT YOU HERE TODAY?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**PATIENT MEDICAL HISTORY [Circle all that Apply]**

Artificial joints or other implants  
Autoimmune disease  
Inflammatory joint disease  
Asthma Breathing Problems  
Endocrine/Hormone Disorder  
Irregular Heart Beat  
Heart Disease/Hypertension

Hay Fever/Allergies  
Diabetes  
Kidney Disease  
Hepatitis  
Thyroid Disease  
Periodontal Disease

Other: \_\_\_\_\_

**PAST PROCEDURAL HISTORY [Circle all that apply]**

Heart Valve Replacement  
Facelift or Necklift  
Botox Injections  
Laser Resurfacing, face or neck

Injection of Dermal Fillers  
Joint Replacement within last 2 yrs  
Skin Biopsy  
Skin Cancer Surgery

Other: \_\_\_\_\_

**SKIN DISEASE HISTORY [Circle all that apply]**

Acne/Rosacea  
Easy Bleeding/Bruising  
Skin Cancer or Pre-cancerous skin lesion

History of Cold Sores  
Allergy to Bee Stings

Other: \_\_\_\_\_

Do you wear Sunscreen? Yes No If yes, what SPF? \_\_\_\_\_

Do you tend to tan or burn when exposed to sun? \_\_\_\_\_

***If you have a history of facial herpes virus (cold sores), there is a possibility that procedures could cause an outbreak, therefore we recommend and can prescribe pre- and post-treatment antiviral medication. Please initial here: \_\_\_\_\_***

**Medications: [Please enter all current medications] \_\_\_\_\_**  
\_\_\_\_\_

**Products or medications currently being used for facial care:**  
\_\_\_\_\_  
\_\_\_\_\_

**Allergies: [Please list all allergies] \_\_\_\_\_**  
\_\_\_\_\_

**Are you allergic to Latex? \_\_\_\_\_ Are you allergic to any metals? \_\_\_\_\_**

**Are you using any tobacco products? \_\_\_\_\_**

## ARE YOU EXPERIENCING ANY OF THE FOLLOWING?

SYMPTOMS	YES	NO
New or changing growth, (enlarging, bleeding, sensitive, coloration, shape)		
Problems with scarring (hypertrophic or keloid)		
Easy bruising, problems with bleeding		
Rash		
Photosensitivity		
Anxiety or depression		
Vision decreased at night		
Headaches		
Yeast infection with antibiotics		
Immunosuppression		
Allergies seasonal (hay fever) or food allergies		
Cold or heat intolerance, thyroid problems		
GI discomfort with antibiotics		
Joint aches or pain		
Chest pain		

### ALERTS: Check all that apply

- Allergy to latex rubber
- Allergy to Penicillin or other antibiotics
- Allergy to Lidocaine, Prilocaine, Betacaine or other local anesthesia
- Artificial joints within past two years
- Pacemaker or defibrillator
- Pre-medication needed prior to procedures
- Blood thinners, aspirin, Coumadin, NSAIDS (Advil)
- Rapid heartbeat with epinephrine
- Pregnancy or planning a pregnancy or nursing
- Infectious Hepatitis (C or B)
- Cold Sores
- Skin Cancer

**Acknowledgement of Notice of Privacy Practices**

I have been presented with a copy of the Notice of Privacy Practices for the office of Wendy A. Epstein, M.D., detailing how my information may be used and disclosed as permitted under federal and state law.

THE FOLLOWING PEOPLE ARE AUTHORIZED TO DISCUSS AND RECEIVE MY PERSONAL HEALTH INFORMATION:

NAME	RELATIONSHIP
_____	_____
_____	_____
_____	_____

**Dr. Wendy Epstein is seeing me for cosmetic dermatology and recommends that I see another dermatologist for regular skin examinations and medical dermatologic care. She has also advised me that it is to my benefit to have a primary care doctor and to follow his or her recommendations for my general health.**

**Patient Name [Please Print]:** \_\_\_\_\_

**Signed:** \_\_\_\_\_ **Date:** \_\_\_\_\_

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