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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