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:

CAN YOU RECEIVE TEXT MESSAGES? PLEASE CIRCLE YES NO

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

EMERGENCY CONTACT: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_TELEPHONE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

WHAT ARE YOUR MAIN CONCERNS THAT BROUGHT YOU HERE TODAY?

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

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**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

COVID-19

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:**

date of last treatment \_\_\_\_\_\_\_\_

Joint Replacement within last 2 yrs

Skin Biopsy

Skin Cancer Surgery

Name of products injected \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Date of last dental cleaning or other dental procedure \_\_\_\_\_\_\_\_\_\_**

**NOTE: PLEASE AVOID DENTAL PROCEDURES TWO WEEKS PRIOR AND POST TREATMENT WITH ANY FILLER INJECTIONS**

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:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

**­­­­­­­­­­­­­­­­­­­­­­­**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

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

**COVID VACCINATION HISTORY**

First shot date \_\_\_\_\_\_\_\_\_\_\_\_

Second shot date \_\_\_\_\_\_\_\_\_\_

Booster date \_\_\_\_\_\_\_\_\_\_\_\_\_\_

**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  antibiotics |  |  |
| Immunosuppression |  |  |
| Allergies seasonal (hay fever) or food allergies |  |  |
| COVID-19 AFTER EFFECTS |  |  |
| 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 |
|  |  |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
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| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  |  |

**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:** \_\_\_\_\_\_\_\_\_\_\_\_\_

Wendy Epstein, M.D., F.A.A.D. 276 River Rd, Grand View, NY 10960 845.398.2343 Fax: 845.215.0035