JUVIVE
WOMEN'S AND PEDIATRIC DERMATOLOGY

Patient Name: _____
Date of Birth: ____/____/_____
Today's Date: ____/____/_____
Appointment Time: _____

New Patient Adult Form

Name: _____
(Please Print First, M, Last)

Date of Birth: _____

Sex: ☐ Female ☐ Male **Marital Status:** _____ **SSN:** _____

Home Address:_____

Email: _____ Can we contact you at this email address? ☐Yes ☐No

Preferred Phone Number: _____**Alternate Phone Number:** _____

Responsible Party (if different from patient) Name: _____
Relationship to patient: _____ Phone:___ _____
Address: _____

Emergency Contact: Name: _____ Phone: _____
Relationship to patient: _____

How did you hear about us? (Please check all that applies) ☐Friends or Family? Their name _____
☐Your Insurance ☐Your Physician ☐Our Website ☐Other Website ☐Yelp ☐Social Media

Preferred Language: _____

Race: ☐White ☐Black/African American ☐American Indian or Native Alaskan
☐Asian ☐Native Hawaiian/Pacific Islander ☐ People of Two or More Races

Ethnicity: ☐Hispanic/Latino ☐Non-Hispanic/Latino ☐ Unspecified

Pharmacy: Name:_____
Address or cross street: _____

Primary Care Physician: _____
phone: _____ Fax: _____

Referring Physician: _____
phone: _____ Fax: _____

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Past Medical History: (please mark & circle all that apply)

- ☐ Arthritis, Lupus, Autoimmune Disease
- ☐ Diabetes, Thyroid disease
- ☐ Hepatitis B, Hepatitis C, HIV, AIDS
- ☐ Liver Disease, Jaundice, Cirrhosis
- ☐ Blood transfusion, Bone Marrow or Organ Transplant
- ☐ Artificial Joints
- ☐ Anxiety, Depression, Eating Disorder, Psychological problems
- ☐ Drug Abuse, Alcohol Abuse
- ☐ Asthma, Tuberculosis, COPD, Emphysema, Chest Disease
- ☐ Hearing Loss
- ☐ Acid Reflux, (GERD), Stomach Ulcers
- ☐ Kidney Disease, Prostatic Disease
- ☐ Faint Spells, Seizures, Stroke, Neurological Disease
- ☐ Migraines, Headaches, Chronic Pain
- ☐ High or Low Blood pressure, High Cholesterol
- ☐ Anemia, Blood/Bleeding Disease
- ☐ Heart Disease, Pacemaker, Valve Replacement, Atrial Fibrillation, Coronary Artery Disease
- ☐ Breast Cancer, Lung Cancer, Colon Cancer, Prostate Cancer, Leukemia, Lymphoma
- ☐ Radiation Treatment
- ☐ Other _____ ☐ None

Have you had any surgeries in the past? (Please indicate dates): _____

_____

Skin Disease History: (please mark all that apply)

- ☐ Biopsy-proven Abnormal Moles
- ☐ Melanoma Skin Cancer
- ☐ Blistering Sunburns
- ☐ Actinic Keratoses/Pre-cancerous lesions
- ☐ Basal Cell Carcinoma
- ☐ Squamous Cell Carcinoma
- ☐ Acne, Acne Scarring
- ☐ Dry Skin
- ☐ Eczema
- ☐ Asthma
- ☐ Hay fever
- ☐ Seasonal Allergies
- ☐ Flaking or Itchy Scalp
- ☐ Psoriasis
- ☐ Other _____
- ☐ Cold sores/Fever blisters/Oral Herpes
- ☐ Genital Herpes
- ☐ Shingles
- ☐ Sexually transmitted disease/Veneral disease

Do you wear Sunscreen? ☐ Yes ☐ No Which Brand? _____

Do you, or have you, tan in a tanning salon? ☐ Yes ☐ No

Do you have a family history of Melanoma? ☐ Yes ☐ No Which Relative? _____

When was your last full skin exam? _____

Medications: (Please enter all current medications): _____

_____

Allergies: (Please enter all allergies and the type of reaction you had): _____

_____

Social History:

Smoking: Do you smoke? ☐ Yes ☐ No Did you smoke in the past? ☐ Yes ☐ No

Illicit Drug Use:: Do you drugs ☐ Yes ☐ No Did you use drugs in the past? ☐ Yes ☐ No

How much alcohol do you drink? ☐ None ☐ Less than 1 drink a day ☐ 1-2 a day ☐ 3 or more a day

Are you sextually active ? ☐ No ☐ 1 Partner ☐ Multiple partners

Are you Sexually active with males, females or both? ☐ Male ☐ Female ☐ Both

Domestic Violence: Do you feel safe at home? ☐ Yes ☐ No

Occupation: _____ Employer: _____

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Patient Name: _____
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Appointment Time: _____

Main reason for today's visit:_____

Location? _____

Qualities of your condition? ☐Red ☐Darkening ☐Itching ☐Flaking ☐Pain/tenderness
☐Burning/Blistering ☐Enlarging ☐Changing ☐Spreading ☐No symptoms ☐Other:_____

How would you describe severity of your condition? ☐Mild ☐Moderates ☐Severe

Duration of your condition? ____days ____ months ____years

Anything that makes your condition better or worse (modifying factors)**?**_____

Have you used any prescription medication for your condition? _____

Have you used any non-prescription treatments for your condition? _____

Is there another skin condition or treatment you would like to discuss? _____

TODAY, are you experiencing any of the following symptoms? (Review of Systems)

☐ Problems with healing or scarring (hypertrophic or keloid)
☐ Problems with bleeding
☐ Fevers or Chills
☐ Unintentional Weight loss
☐ Immunosuppression
☐ Joint Aches/Muscle Weakness
☐ Headaches
☐ Shortness of Breath
☐ Chest Pain
☐ Abdominal Pain
☐ None

! SAFETY ! To help us provide safe treatments, please mark all that apply to you today:

- Pregnancy or planning a pregnancy ☐Yes ☐No
- History of MRSA/resistant staphylococcus infection ☐Yes ☐No
- History of or exposure to HIV infection ☐Yes ☐No
- History of or exposure to Hepatitis B or Hepatitis C ☐Yes ☐No

- Allergy to any of the following? ☐Latex ☐Adhesives ☐Lidocaine ☐Topical Antibiotics ☐Bees ☐No
- Do you get rapid heartbeat with numbing injections (epinephrine) ☐Yes ☐No
- Do you have a Defibrillator, Pacemaker, Artificial heart valve, or Artificial joints placement? ☐Yes ☐No
- Are you required to take antibiotic premedication prior to surgical procedures? ☐Yes ☐No
- Are you on any blood thinners? _____ ☐Yes ☐No
- Have you taken any of the following in the last 2 weeks?

☐Anti-inflammatories or muscle relaxants such as Ibuprofen/Motrin/Advil/Nuprin
☐Aspirin (or aspirin containing medications) ☐Vitamin E ☐Omega 3
☐ Ginkgo Biloba, Garlic, Ginseng, Ginger, Dong quai, Ephedra, Feverfew, St. John's wort ☐None

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Skincare and Cosmetics (You may skip this section if you do not wish to discuss with doctor today)

Skincare Regimen:

What is your morning skincare routine?_____

What is your evening skincare routine? _____

Do you do any weekly at home treatments such as masks etc?_____

Do you or have you gotten any in-office cosmetic treatments in the past?

Where you happy with the results? ☐ Yes ☐ No

Would you be interested in discussing any of the following cosmetic services?

☐ Skincare Consultation for Improvement of Complexion

☐ Light or Laser Treatment for Brown Spots
☐ Laser for Facial Redness/Rosacea
☐ Light or Laser Treatment for Glow & Mild Rejuvenation
☐ Fractional Laser for Moderate Rejuvenation
☐ Skin Resurfacing for Major Rejuvenation
☐ Acne Scar Treatment
☐ Hair reduction
☐ Laser Stretch Mark Treatment
☐ Laser Melasma Treatment
☐ Laser for Stretch marks

☐ BOTOX® or Xeomin® for Prevention and Treatment of Facial Wrinkles
☐ BOTOX® or Xeomin® for Brow Lift
☐ BOTOX® or Xeomin® for Sweating
☐ Injectable Fillers for Prevention and Treatment of Facial Folds and Facial Volume Loss
☐ Lip Filler
☐ Eyelid Rejuvenation
☐ Hand rejuvenation

☐ KYBELLA® injections for fat below the chin "double chin."

☐ Chemical Peels