account#_____

grand PEARL
SKIN BEAUTY BODY

Patient Information Form- *please print*

Patient Name _____ Date of Birth _____age_____

Address _____ Home phone _____

City _____ State _____Zip _____ Cell Phone _____

Email address _____ Marital status M S W D Gender M F

Would you like to receive information regarding our product specials, educational seminars and events?
Yes No

Employer_____ Phone _____

May we contact you at work? Yes No Social Security #_____

If under 18:

Mother/Legal guardian Name_____ Phone _____

Address_____

Father Name_____ Phone _____

Address_____

How did you hear about our office? _____

Next of Kin/ Emergency Contact _____ Phone_____

Please indicate if there is anything we need to know to provide you more personal care_____

_____

I realize that skin care is cosmetic and not covered by insurance. I am aware that I am responsible for all charges.

_____ _____
(patient/parent/guardian signature) *(date)*

_____ _____
(witness signature) *(date)*

☐ **I Have Received a Copy of the the Notice of Privacy Practices at Grand Pearl**

*Account#*_____

grand PEARL
SKIN BEAUTY BODY

Women's Wellness Consult

What is your main concern for today's consult?_____

Have you consulted any other physician for this problem? If yes, who?_____

Allergies/reaction:_____

Medications (Prescription)/ what you take them for	**Supplements/Vitamins (Over the Counter)**
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Your current Height:_____

Your current Weight:_____

Surgeries/Hospitalizations:

_____date_____

_____date_____

_____date_____

_____date_____

Anesthesia History:

Have you ever had anesthesia? Y N

Nausea/Vomiting after? Y N

Motion sickness? Y N

Malignant hyperthermia? Y N

OB/GYN History:

Age of first period/menses:_____ years old

Current frequency and duration of periods: every _____ days, lasting _____ days

First day of last menstrual period:_____

Do you have any spotting or bleeding between periods? Y N

Do you have any spotting or bleeding after intercourse? Y N

Do you have pain associated with your period? Y N

If you have pain, is it: Before menses During menses Both before & during

Are you pregnant or trying to become pregnant? Y N

Are breastfeeding? Y N

Are you menopausal? Y N

At what age did you go through menopause?_____

Are you currently sexually active? Y N

What is your current form of birth control?_____

Number of pregnancies:_____ Number of Deliveries:_____

*Account#*_____

Do you have a history of:			**Have you had:**		
Breast Cancer	Y	N	Hysterectomy w/removal of ovaries	Y	N
Uterine/Endometrial Cancer	Y	N	Hysterectomy (ovaries remain)	Y	N
Ovarian Cancer	Y	N	Oophorectomy (removal of ovaries)	Y	N

Past Medical History:

(patient signature) (date)

*Account#*_____

Endometriosis	Y	N	Tuberculosis (TB)	Y	N	Blood clots	Y	N
Fibroids/Polyps	Y	N	History of MRSA	Y	N	Stroke	Y	N
Polycystic Ovarian dz	Y	N	Heart Disease	Y	N	Diabetes	Y	N
Fibrocystic Breast dz	Y	N	High Cholesterol	Y	N	Fibromyalgia	Y	N
Acne	Y	N	Heart Attack	Y	N	Keloids	Y	N
Thyroid Disorder	Y	N	Heart Arrhythmia	Y	N	Gastric Surgery	Y	N
HSV (Herpes)	Y	N	High Blood Pressure	Y	N	Bleeding problem	Y	N
AIDS/HIV	Y	N	Seizures	Y	N	Autoimmune dz	Y	N
Hepatitis	Y	N	Concussion	Y	N	Asthma	Y	N

Do you have any of these symptoms? (Check all that apply)

Symptom	**Never**	**Mild**	**Mod**	**Severe**
Depressive mood	_____	_____	_____	_____
Fatigue	_____	_____	_____	_____
Memory loss	_____	_____	_____	_____
Mental confusion/Brain “fog”	_____	_____	_____	_____
Decreased sex drive/libido	_____	_____	_____	_____
Sleep problems	_____	_____	_____	_____
Mood changes/irritability	_____	_____	_____	_____
Migraine/severe headaches	_____	_____	_____	_____
Difficulty achieving orgasm	_____	_____	_____	_____
Bloating	_____	_____	_____	_____
Weight gain	_____	_____	_____	_____
Breast tenderness	_____	_____	_____	_____
Vaginal dryness	_____	_____	_____	_____
Hot flashes/Night sweats	_____	_____	_____	_____
Dry/wrinkled skin	_____	_____	_____	_____
Hair loss	_____	_____	_____	_____
Cold intolerance	_____	_____	_____	_____
Joint pain/Swelling	_____	_____	_____	_____

I realize that accurate medical information is essential for safe and proper medical care. The above information is true and accurate to the best of my knowledge.

_____

(patient signature) (date)