Ford Center for Anti-Aging & Pain Management
Dr. Dennis C. Ford

We are glad we may serve you! Please provide the following for today's therapy:

Your Name: _____ Today's Date: _____
What would you like us to help you improve today? _____
_____

➢ **Laser Therapies:**

Last date of sun exposure, tanning bed, spray tan or tanning cream? _____
If you use Retin-A, when did you last apply to skin? _____
Have you use bleaching creams, hair removal creams or waxed the area to be treated in the last six weeks? Yes _____ No _____
When did you last receive laser therapy? _____
List all products applied to the treatment are in the past 24 hours? _____
_____
Do you have any permanent cosmetics? Yes _____ No _____
Have you had facial filler in the last 12 months? Yes _____ No _____
Do you have any cosmetic implants? Yes _____ No _____
Please circle if you have take any of the following in the last two weeks:
St. John's Wort, Bufferin, Advil, Ibuprofen, Nuprin, Vitamin E, Fish oil, Aspirin.

➢ **Botox, Juvederm:**

Do you currently have any facial implants? _____
Please list previous treatments you have received at any facility:
Botox (date) _____ Areas treated _____
Juvederm (date)_____ Areas treated _____
Other (specify) _____ Areas Treated _____

➢ **Hormone Replacement Therapies:**

What is the last date you had hormone levels tested? _____
Where did you have these performed? _____
List hormone creams, injections or medications you currently use (include Thyroid medications.)
_____
What other hormone therapies have you tried? _____
Please circle any of the following that apply to you: anxiety fatigue insomnia headaches

mood swings	erectile dysfunction	organ removal	hot flashes
night sweats	irregular menses	dry skin or hair	weight gain
weight loss	vaginal dryness	breast tenderness	memory loss
irritability	aggressiveness	thinning eyebrows	fluid retention
hair loss	decreased libido	fibrocystic breast disease	

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