FORD CENTER for ANTI-AGING PAIN MANAGEMENT

Welcomes you...

Please provide the following information so we may better serve you.

Your legal name _____ Today's Date _____
(First) (Middle) (Last)

What name should we call you? _____ Birth Date _____

Are you: male or female Are you: single , married or other_____

Home address: _____ City _____ State & zip _____

Home phone _____ cell phone _____ work phone_____

Please circle the above phone number where we should contact you.

Do you permit us to leave a message for you at the above number? Yes or No

Email_____ employer: _____ occupation _____

Spouse's name _____ Do you authorize us to discuss your information with your spouse if they call? Yes or No

Please list an emergency contact who does not live with you _____

Relationship _____ home phone _____ cell phone _____

Please indicate which concerns you might want to improve:

- ☐ fine lines around eyes
- ☐ drooping corners of mouth
- ☐ laser skin resurfacing
- ☐ laser micropeel
- ☐ age or sun spot removal
- ☐ hyperbaric oxygen therapy
- ☐ desire to quit smoking
- ☐ lines around lips
- ☐ laser hair reduction
- ☐ removal of skin lesions
- ☐ skin care regimen
- ☐ mole or skin tag removal
- ☐ tired-looking eyes
- ☐ uncontrolled appetite
- ☐ forehead creases
- ☐ nasal wolf lines
- ☐ scar revision
- ☐ laser vein therapy
- ☐ laser photo facial
- ☐ skinny lips
- ☐ weight gain

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Medical History

Family History:

Mother's Age _____ Health Problems _____

Father's Age _____ Health Problems _____

Number of sibling's _____ Health Problems _____

Social History: Single _____ Married _____ Widowed _____ Divorced _____

Occupation: _____

Out of Work? Yes___No ___ Disability? Yes ___ No ___Retired? Yes ___ No ___

PLEASE CHECK ALL THAT APPLY TO YOUR HEALTH.....

ARE YOU PRESENTLY ON A BLOOD THINNER: Yes _____ No _____

HEART: Heart Trouble _____ Heart Murmur ___ High Blood Pressure____
Chest Pain ____Heart Attack _____ Palpitations _____ Leg Swelling _____
Pace-Maker _____

LUNGS Cough _____Wheezing _____Asthma _____ Bronchitis _____ COPD _____

Pneumonia _____ TB _____ Sputum Color (yellow, brown, blood) _____

EYES Glasses/Contacts _____ Pain _____ Excessive Tearing _____
Double Vision _____ Glaucoma _____ Cataracts _____

EARS Ringing in Ears _____ Dizziness _____ Earaches _____ Infection _____
Drainage _____ Difficulty Hearing _____ Hearing Impaired _____
Hearing Aid (L___R___)

NOSE & SINUS Frequent Colds ____ Nasal Stuffiness _____Hay Fever Nosebleed _____
Sinus Trouble (explain) _____

MOUTH & THROAT Bleeding Gums ____ Sore Tongue ____ Sore Throat ___ Hoarseness ____

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SKIN Rashes _____ Lumps _____ Itching _____ Drying _____ Color Change ___
Sensitive Skin _____ Change in Hair/Nails _____

HEAD Headache _____ Head Injury _____

NECK Lumps _____ Pain _____ Swelling _____

GASTRO- Trouble Swallowing ____ Heartburn _____ Ulcer _____ Nausea _____
INTESTINAL Constipation ____ Diarrhea _____ Hemorrhoids _____ Hepatitis ____
Jaundice _____ Gallbladder _____

ENDOCRINE Diabetes _____ Thyroid Disorder _____

KIDNEYS & Frequent urination at night _____ Pain during urination _____
BLADDER Frequent urge for urination _____ Unable to control bladder _____
Diagnosis of infection _____ Kidney stones _____

FEMALES Menstrual Problems ___ Pelvic Inflammatory Disease ___Menopause__
ONLY Sexually Transmitted Disease _____

MALES Testicular Pain/Masses _____ Prostate Problems _____ Hernia _____
ONLY Sexually Transmitted Disease _____

MUSCULOSKELETAL Muscle Pain ___ Muscle Cramps ____Artificial Joints ____
Gout ____ Joint/Pain Stiffness ____ Backache ____ Arthritis ____

VASCULAR Leg Pain __ Leg Cramps ___ Varicose Veins ___Thrombophlebitis __
DVT ____

NEUROLOGIC Fainting ____ Light Headedness ___ Blackouts ____
Seizures ____ Tremors ___ Numbness ____ Tingling ____ Pins & Needles ____
Memory Problems ____

OVERALL Weakness ____ Fatigue ___ Recent Weight Loss ___ Weight Gain ___
Fever __ Hot/Cold Intolerance ___ Excessive Sweating ___ Easy Bruising ___
Tension __ Nervousness ___ Depression ___ Anxiety ____ Panic Attacks ____

ALLERGIES Hay Fever ____ Food Intolerance ____ Frequent Infections____
Other _____

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Please list all MEDICATION allergies:

Medical History:

Illnesses: _____

Hospitalizations: _____

Injuries: _____

Psychiatric Illnesses: Depression ____ Anxiety ____ Panic Attacks ____

Other (please describe): _____

Surgical History:

Surgery: _____ Date: _____

Surgery: _____ Date: _____

Surgery: _____ Date: _____

Surgery: _____Date: _____

Habits:

1) Alcohol.....Beer amount per week _____ Wine amount per week _____

   Hard liquor amount per week _____

2) Tobacco..... Yes ☐ No ☐

3) Packs per day _____ Years _____

4) Recreational Drugs? Yes ☐ No ☐

   Type _____ Route _____

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Please check all medical conditions or therapies that apply to you:

☐ pregnancy / recent childbirth	☐ hormone imbalance	☐ epilepsy
☐ high blood pressure	☐ varicose veins	☐ diabetes
☐ currently smoking	☐ facial surgery	☐ eczema
☐ migraine headaches	☐ cosmetic implants	☐ asthma
☐ chemotherapy	☐ thyroid abnormalities	☐ acne
☐ metal bone pins or plate	☐ hormone replacement therapy	☐ cancer
☐ panic attacks / anxiety	☐ permanent cosmetics	☐ rosacea
☐ brain or neurological surgery	☐ herpes zoster	☐ HIV positive
☐ heart condition	☐ unwanted hair growth	☐ age/sun spots
☐ keloid or unusual scars	☐ Accutane or gold therapy	☐ chest pain
☐ hysterectomy /oophorectomy	☐ hot flashes / night sweats	☐ seborrhea
☐ excessive bleeding	☐ psychological counseling	☐ sun tanning
☐ unintentional weight gain	☐ unintentional weight loss	☐ depression

Please list any other health concerns or illnesses not listed above: _____

_____

Please list any surgeries or injuries you had in the last 12 months: _____

_____

Please list any medications you currently take, including hormone injections or topical creams you may use _____

_____

Please list any food, cosmetic or drug allergies _____

_____

What would you like us to help you improve today? _____

For laser therapies, please provide the following dates:

Last use of Retin A _____ last menstrual period (females only) _____

Last taken Accutane or gold therapy _____ Glycolic treatment _____

Last microdermabrasion _____ last laser therapy _____

Last use of bleaching creams, hair removal creams or waxing to the area to be treated today _____ last sun tan or tanning bed use _____

Last Botox treatment _____ Last filler injections _____

Please circle any of the following if you have taken in the last two weeks:
St. John's Wort, Bufferin, Advil, Ibuprofen, Nuprin, vitamin E, fish oil, aspirin

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For hormone therapies, please circle any of the following symptoms that you experience: anxiety, fatigue, insomnia, headaches, mood swings, erectile dysfunction, hair loss, organ removal, hot flashes, night sweats, irregular menses, irritability, vaginal dryness, breast tenderness, dry skin or hair, aggressiveness, memory loss, thinning eyebrows, fluid retention, decreased libido, memory loss, weight gain, weight loss
What other hormone therapies have you tried?_____

_____

When did you last have your hormone levels tested? _____

If you are interested in **weight loss therapy**, please indicate:

Have you ever been diagnosed with diabetes? Yes☐ No☐ If yes, when? _____
Please list any heart conditions you may have _____
or please check ☐ I have no known heart conditions
If you have you had any history of cancer, please describe_____
or please check ☐ I have no history of any type of cancer.
What is your desired weight? _____ What is your current weight? _____

Please indicate how you learned of our services.....

☐ yellow pages	☐ newspaper	☐ friend _____
☐ TV / radio ad	☐ brochure / flyer	☐ website _____
☐ physician	☐ office poster	☐ other _____

Authorization

I certify that this information provided is complete and accurate to the best of my knowledge. I understand that payment for all services rendered at Ford Center for Anti-Aging and Pain Management are due at the time that services are provided. My information will remain confidential and will only be discusses with any names I wrote above. I will submit all changes in writing. I authorize Dennis C. Ford, MD and his representatives to provide therapeutic and cosmetic services. I hereby permit Dennis C. Ford, MD or any assistant that he may designate to take photographs for diagnostic and evaluation purposes. I further authorize him to use such photographs for teaching purposes, to illustrate scientific papers, books, lectures, medical research, public education, pamphlets or via website. These photographs will remain the physician's property. I understand that in any such use, I will not be identified by name.

_____ _____

Signature Date

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