

Great Lakes Gynecology and Aesthetic Center

New Patient Information

NAME: _____ Birth Date: ____ / ____ / ____ Age: _____

Address: _____ Sex: **M / F**

City: _____ State: _____ Zip Code: _____

Home: () _____ Work: () _____ Cell: () _____

E-mail: _____

Emergency Contact: _____ Telephone: () _____

Allergies: _____

How did you hear about Great Lakes Gynecology and Aesthetic Center? _____

Please put a check mark next to the procedures about which you would like to receive more information:

_____ Acne Treatment

_____ Botox to Flatten and Prevent Wrinkles

_____ Enhanced Skin Rejuvenation

_____ Collagen Augmentation

_____ Wrinkles

_____ Skin Toning or Pore Size Reduction

_____ Facial Redness

_____ Brown Spots

_____ Sun Damage

_____ Broken Capillaries

_____ Spider Veins/Leg Veins

_____ Hair Reduction

_____ Shaving bumps/Ingrown hair

Please put a check mark next to a past or current medical condition:

Medical History:

_____ Lupus or other auto-immune deficiency (A)

_____ Pregnant (A)

_____ Bleeding abnormalities (A)

_____ Treatment with Accutaine® in the last year (A)

_____ Treatment with Tetracycline® in the last month (A)

_____ Keloid or very thick scarring (A)

_____ Psoriasis or Vitiligo (A)

_____ Pulmonary embolism/blood clot (V)

_____ Leg ulcer or Phlebitis (V)

_____ Blood thinning medication (V)

_____ Coumadin anti-clotting agents (A)

_____ Rheumatoid Arthritis "Gold" Therapy (A)

_____ Cystic Acne (P)

_____ Herpes simplex or fever blisters (A)

_____ Diabetes (A)

_____ Epilepsy (A)

_____ Scars that turn white or brown (A)

_____ Dark spots after pregnancy, skin injury (A)

_____ HIV (A)

_____ Hepatitis (A)

_____ Waxing/Plucking/Electrolysis within last four weeks (HR)

_____ Hirsutism (HR)

_____ Transplant Anti-Rejection Drugs (HR)

_____ Chemical Peels, Dermabrasion, Laser

_____ Resurfacing or Face Lift (A)

Please list any medications or herbal supplements that you are currently taking:

