REGEN CLINIQ

Integrative Medical Aesthetics & Well-Being

Patient's Name:_____
First Middle Last

Address _____

City _____ State _____ Zip code _____

Telephone numbers: Home _____Work/Cell _____

Email: _____ DOB: _____

SS#_____ Driver's License # _____

If someone other than the patient is responsible for payment, please complete the following:

Name of responsible party_____SS#_____

Relationship to patient _____ Phone# _____

Employer & address

_____

Are you currently receiving health care? ❑Y ❑N
If yes, please list your current
providers_____)_____

If no, when and where did you last receive medical care_____

Are you aware of any allergies to food, drugs, or other environmental allergens (cats, mold, dust)? If yes, please list allergen, reaction, and severity

_____

SELF & FAMILY HISTORY

Please list past hospitalizations or surgeries

_____

_____

_____

Please list any recent lab work with any abnormal results

_____

What diagnostic imaging studies have you had?

- ❑ Electrocardiogram
- ❑ Ultrasound
- ❑ Bone density scan
- ❑ MRI
- ❑ CT scan
- ❑ Electroencephalogram
- ❑ Colonoscopy/Sigmoidoscopy
- ❑ X-rays
- ❑ Mammogram
- ❑ Other

MEDICATIONS AND/OR SUPPLEMENTS

Do you take or use any of the following?

- ❑ Pain relievers (aspirin, ibuprofen)
- ❑ Cortisone (cream or pills) or other steroids
- ❑ Blood Thinners (Coumadin, Plavix)
- ❑ Sleeping Pills
- ❑ Thyroid medication
- ❑ Tranquilizers
- ❑ Other
- ❑ Diet pills, appetite suppressants
- ❑ Insulin
- ❑ Vitamins
- ❑ Antibiotics
- ❑ Antacids
- ❑ Laxatives

Please list any prescription medications, over-the-counter medications, vitamins, or other supplements you are taking with dosages and brand names, if possible: (Please add how long you have been on this medication)

1. _____
2. _____
3. _____
4. _____
5. _____

<u>GENERAL</u>

Height _____ Weight _____ lbs Weight one year ago _____ lbs
Maximum weight _____ lbs When? _____
Are you happy with your current Wt?
❑Y ❑N

Energy Level
❑1 ❑2 ❑3 ❑4 ❑5 ❑6 ❑7 ❑8 ❑9 ❑10

At what time of day is your energy the best? _____
Worst? _____

Is there any condition (physical, mental, emotional) from which you feel that you have not fully recovered? _____

Please tell me about your desired outcomes that you would like to achieve aesthetically during this treatment session?

Aesthetic Questions:

QUESTIONS	YES	NO
Are you pregnant, trying to get pregnant or lactating (nursing)?		
Have you had Botox before?		
Were you satisfied with the results?		
Have you had any dermal filler procedures before?		
Were you satisfied with the results?		
Have you ever had eyelid/ eyebrow droop after Botox or other Neurotoxins?		
Do you show a lot of upper eyelid when your eyes are open?		
Do your eyelids feel extra heavy when you don't get enough sleep?		
Do your eyelids droop without sleep?		
What are your areas for treatment that are of special concern to you?		

FAMILY HISTORY

Please note which relative and age of onset if known. Example P-Gpa 50 (paternal grandfather at 50). Please include 1st and 2nd degree relatives only.
Do you have a family history of any of the following (please circle)?

Alcoholism/addiction	Depression	Liver Disease
Allergies	Diabetes	Mental Illness
Anemia	Gallbladder Disease	Skin Conditions
Arthritis	Goiter	Stroke
Asthma	Hayfever/Hives	Suicide
Autoimmune	Headache/Migraines	Thyroid Problems
Cancer, type?	Heart Disease	Tuberculosis
Cataracts	Heart Murmur	Other _____
Celiac	High Blood pressure	

Is your father living? Yes; his age _____ No; age at time of death _____
Cause of death _____

Is your mother living? Yes; her age ____ No: age at time of death _____
Cause of death _____

Do you have siblings? If so, how is their health?
_____

CHILDHOOD ILLNESSES

Any major health concerns (i.e. Polio, Rhuematic Fever, etc.)
_____

PAST IMMUNIZATIONS

Please circle any of the following immunizations you have had. If unsure, please write a question mark beside the immunization.

Diptheria Pertussis Polio Tetanus

Measles/Mumps/Rubella (MMR) Other _____

REVIEW OF SYSTEMS (self)

Condition	Present Condition	Problem in the past	Never had the condition
Headaches			
Head Injury			
Migraines			
Jaw/TMJ Problems			
Tinnitus (Ear Ringing)			
Earaches			
Excessive Wax			
Impaired Hearing			
Neck Lumps			
Goiter			
Swollen Glands			
Neck Pain or Stiffness			
Rashes			
Itching			
Psoriasis			
Acne, Boils			
Loss of Hair			
Eczema, Hives			
Cold Sores			
MRSA			
Hyper/Hypo-Pigmentation			
Night Sweats			
Joint Swelling			
Arthritis			
Osteoporosis			

Condition	Present Condition	Problem in the past	Never had the condition
Muscle Spasms			
Broken Bones			
Muscle Pain			
Join pain/stiffness			
Hoarseness			
Sore Throat			
Shortness of Breath			
TB			
Cough			
Asthma/wheezing			
Chest Pain			
Heart Attack			
Stroke			
Murmur			
Blood Clots			
High/Low Blood Pressure			
Diabetes			
Palpitations			
Varicose Veins			
Easy Bruising			
High Cholesterol			
Anemia			
Raynauds			
Fainting			
Seizures			
Numbness			
Memory Loss			

Condition	Present Condition	Problem in the past	Never had the condition
Anxiety			
Depression			
Eating Disorder			
Substance abuse			
Tension			
Thoughts of Suicide			
Hypothyroid			
Hyperthyroid			
Cold Intolerance			
Heat Intolerance			
Sexually Active			
Infections (ie Herpes, HIV)			
Bloating			
Nausea			
Diarrhea			
Constipation			

Any metal implants/devices? ❑**Y** ❑**N**

Is there anything else you would like us to know in order to serve you better?

_____

_____

_____

List your top 3 goals for today?

_____

_____

_____

Habits

Please write what you last had for breakfast, lunch, dinner, and snacks **in the last 24 hours**

Breakfast _____
Lunch _____
Dinner _____
Snacks _____
Fluids. _____

Do you have any dietary restrictions and why?

_____

Please indicate the following

Smoke ❑Y ❑P ❑N If yes, amount_____

Alcohol ❑Y ❑N If yes, amount_____

Caffeine (soda, coffee, tea, etc...) ❑Y ❑N If yes, amount_____

TV Hours per day ❑0-1 ❑1-3 ❑3-4 ❑4+

Exercise ❑Y ❑N

If yes, amount and type_____

Main Interests/Hobbies

_____

Do you have a spiritual practice: ❑Y ❑N

How many hours do you sleep? _____ Do you wake rested? ❑Y ❑N

Do you have any stress management practices? ❑Y ❑N

What do you do to relax?

_____

Do you have a good support system (friends, family)?

_____

Exposed to chemicals/tobacco at home or at work? ❑Y ❑P ❑N

If yes, list: _____

Any toxic exposure known?

_____

How motivated are you to make changes in your life to improve your health (10=most)?

❑1 ❑2 ❑3 ❑4 ❑5 ❑6 ❑7 ❑8 ❑9 ❑10

What changes are you willing to make to improve your health?

❑Lifestyle Changes ❑Take Supplements ❑Smoking Cessation ❑Sleep Patterns ❑Recreational Hours/Hobbies ❑Exercise ❑Nutrition changes ❑Counseling ❑Alcohol reduction/cessation

Please list the Name, Address, and phone number to the Pharmacy you would like medications sent to_____

_____

Patient Signature_____ Date_____