PATIENT INFORMATION

DATE: ______________________________

Ms. Miss Mr. Mrs.____
CIRCLE ONE **FIRST NAME** **MIDDLE INITIAL** **LAST NAME**

MAILING ADDRESS: ____
STREET & APT # **CITY** **ZIP**

EMAIL ADDRESS:______________________________ GENDER: ☐ M ☐ F AGE:________

Mark Primary

HOME PHONE:______________________________ ☐ DATE OF BIRTH: ______________________

WORK PHONE:______________________________ ☐ SOCIAL SECURITY #: ______________________

MOBILE PHONE:______________________________ ☐ PREFERRED LANGUAGE: ______________________

SINGLE ☐ MARRIED ☐ DIVORCED ☐ SEPARATED ☐ WIDOWED ☐

EMPLOYER:______________________________ OCCUPATION: ______________________

ADDRESS: ____
STREET **CITY** **ZIP**

EMERGENCY CONTACT:____
FIRST NAME **MIDDLE INITIAL** **LAST NAME**

PHONE NUMBER:______________________________ RELATIONSHIP:______________________

HAVE YOU OR ANYONE YOU KNOW EVER BEEN SEEN HERE BEFORE? ☐ YES ☐ NO

IF YES WHO? ______________________________

WHERE DID YOU HEAR OF OUR OFFICE? **(CHECK ALL THAT APPLY)**

TELEVISION
9 NEWS ☐ UNIVISION ☐ INTERNET SEARCH ENGINE ☐ WALK IN/DRIVE BY ☐

YELLOWPAGES WORD OF MOUTH ☐ FINANCE COMPANY ☐
PRINTED ☐ ONLINE ☐
INTERNET LINK/WEBSITE SE- ☐ ROTAMD.COM ☐

PATIENT/EMPLOYEE:______________________________ ☐ TOM MARTINO ☐

REFERRING DOCTOR:______________________________ ☐ BETTER BUSINESS BUREAU ☐

OTHER (PLEASE SPECIFY):______________________________ ☐ MEDICAL FACILITY ☐

PLEASE CIRCLE THE SOURCE ABOVE THAT LED YOU TO OUR PHONE NUMBER.

PATIENT HEALTH HISTORY FORM

Patient Name: ____________________ Date: ____________

Age: ________ Sex: ☐ M ☐ F Height: _______ Weight: ________ Medical Allergies: ____________

Primary Care Physician: ____________________

CURRENT MEDICATIONS: / SURGERIES REQUIRING ANESTHESIA:

Drug Name	Reason for Taking	Surgery Type	Approximate Year
______	______	______	______
______	______	______	______
______	______	______	______
______	______	______	______

(Include Herbal & Over the Counter Medications)

REASON FOR VISIT: ____________________

HEALTH HISTORY

SELF		FAMILY
☐	Bleeding/Clots	☐
☐	Anesthesia Prob	☐
☐	Seizures/Fainting	☐
☐	Diabetes	☐
☐	Depression/Anxiety	☐
☐	Thyroid Disease	☐
☐	Anemia	☐
☐	Heart Disease	☐
☐	High Blood Press	☐
☐	Lung Disease	☐
☐	HIV/Aids	☐
☐	Kidney Disease	☐
☐	Asthma	☐
☐	Hepatitis	☐
☐	Cancer	☐
☐	**NONE APPLY**	☐

SOCIAL HISTORY

Tobacco Use: ☐ Y ☐ N Quantity: ________

Sun Exposure: ☐ Minimal ☐ Moderate ☐ Excessive

Alcohol Use: ☐ Y ☐ N Quantity: ________

Exercise: ☐ Daily ☐ Occasional ☐ Never

Tanning Bed: ☐ Y ☐ N Frequency: ________

Sunscreen Use: ☐ Never ☐ Occasional ☐ Daily

NOTES:

____

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WOMEN

Post Menopausal: Y ☐ N ☐

Possibly Pregnant: Y ☐ N ☐

Total # of Pregnancies: ______

Number of Children: ________

Current Bra Size: __________

Preferred Cup Size: ________

Last Mammo: ____________

GENERAL

History of Poor Healing: Y ☐ N ☐

History of Thick Scars: Y ☐ N ☐

Recent Weight Gain/Loss: Y ☐ N ☐

Amount +/- ____________

Visual Health Concern: Y ☐ N ☐

Please specify: ____________

MEN

Past/Present Steroid Use: Y ☐ N ☐

Testosterone Supplements: Y ☐ N ☐