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NAME \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_ AGE \_\_\_\_\_

ADDRESS [PLEASE INCLUDE CITY/STATE/ZIP] \_\_\_\_\_

EMAIL \_\_\_\_\_ OCCUPATION \_\_\_\_\_

PRIMARY PHONE \_\_\_\_\_ SECONDARY PHONE \_\_\_\_\_

HOW WOULD YOU LIKE US TO REACH YOU?  PRIMARY PHONE  SECONDARY PHONE  EMAIL

WHO MAY WE THANK FOR REFERRING YOU?

PHYSICIAN REFERRAL, WHO? \_\_\_\_\_ OTHER, PLEASE SPECIFY: \_\_\_\_\_

HAVE YOU HAD SERIOUS ILLNESS/INJURY/HOSPITALIZATION WITHIN 5 YEARS? \_\_\_\_\_

DO ANY OF THE FOLLOWING CONDITIONS APPLY TO YOU?

- rheumatic heart disease congenital heart disease heart murmur heart attack coronary occlusion stroke
- diabetes asthma epilepsy seizures fainting spells hepatitis
- liver disease arthritis stomach ulcer kidney disease contact lens wearer broken capillaries
- cancer rosacea lupus multiple sclerosis bleeding disorders varicose veins
- fever blisters spider veins dry skin oily skin pregnant/lactating herpes
- neurological disorders myasthenia gravis sensitive skin tanning beds hyper-hypothyroidism other:\_\_\_\_\_
- smoker use of chemical tanners chronic pain psychiatric disorder history of eating disorder \_\_\_\_\_
- constipation history of substance abuse family history of breast cancer hypertension (high blood pressure)

HAVE YOU HAD ANY OF THE FOLLOWING?

- sclerotherapy spider vein removal chemical peel hysterectomy laser treatment facial surgery
- acutane therapy hormone replacement steroid therapy hair reduction waxing retin A
- birth control pills BOTOX or Dysport skin rejuvenation electrolysis radiation IPL
- liposuction dermal fillers fat transfers depilation microdermabrasion pacemaker
- permanent cosmetics cellulite treatment blood transfusion abnormal bleeding deep vein thrombosis
- cosmetic surgery: type \_\_\_\_\_

DO YOU HAVE ANY ALLERGIES TO ANY MEDICATIONS/ANESTHESIA? IF YES, PLEASE SPECIFY \_\_\_\_\_

WHAT MEDICATIONS DO YOU TAKE DAILY? [INCLUDE ALL SUPPLEMENTS/HERBAL REMEDIES]

I have answered all questions truthfully and revealed all of my medical conditions and agree to alert FUZION/Dr. Goodkind of all changes that occur. I also consent to being photographed as an aid to my treatment and that my photographs may be used for study reporting. I am aware that all information, including photographs are confidential.

SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_