FAMILY HISTORY OF: (circle Yes or No)

- Cancer: **Y / N**
- Bleeding: **Y / N**
- Keloid Formation: **Y / N**
- Eczema/Psoriasis/Rosacea: **Y / N**
- Genetic Disorders: **Y / N**

FEMALE PATIENTS: (circle Yes or No)

- Last Menstrual Period: _____
- **Are you pregnant? Y /N**
- **If yes, when is your due date?:** _____

SOCIAL HISTORY: (Circle Yes or No)

- Do you smoke? **Y / N:** ___ packs/day
- Do you drink? **Y \ N:** ___drinks/day
- Do you use drugs? **Y / N:** _____what kind?
- Occupation: _____
- Hobbies: _____

Dermatology (Skin) History

Please Check One:	YES √	NO √
Have you ever had a complete head to toe skin check?		
Would you like one?		
Do you bruise easily?		
Do you sunburn easily?		
Do you scar easily (Keloid)?		
Do you heal poorly?		
Do you have any bleeding problems?		
Do you develop rashes to anything?		
Do you have eczema, psoriasis, or rosacea?		

Please Check One/Describe:	YES √	NO √
Have you ever seen a Dermatologist? Date of last visit:		
Have you ever been on ACCUTANE? When:		
Do you currently have any sores, wounds, cuts, or lesions? Describe:		
Is your skin exposed outdoors often? Hours/Week:		
Do you use self-tanners or tanning beds? Date of last exposure:		
Do you have Hyperpigmentation (darkening of skin)?		
Do you have Hypopigmentation (lightening of skin)?		
Do you have any marks or scars from physical trauma?		
Do you get cold sores, canker sores, or fever blisters?		

Have you ever used any of the following hair removal methods in the **past six weeks**? (Circle Yes or No)

- Shaving: **Y / N**
- Waxing: **Y / N**
- Electrolysis: **Y / N**
- Plucking: **Y / N**
- Stringing: **Y / N**
- Depilatories: **Y / N**

Please list any cosmetic products you currently use:

1) _____ 2) _____
3) _____ 4) _____
5) _____ 6) _____

I, the undersigned, agree that the information provided is accurate and true to the best of my ability. I agree to the physical examination and consultation. I understand that medicine is not an exact science and that no guarantees as to medical or cosmetic results have been given to me. I further understand that AnuYou Institute recommends that I have a total body skin examination performed annually in order to detect abnormal growths.

Cancellation Policy:

We request a minimum of 24 hours notice for cancellations of any scheduled appointments. Late cancellations will be charged 50% of treatments scheduled which must be paid prior to the next appointment. Late arrivals may result in a reduced or cancelled service. We expect unforeseen circumstances to arise and reserve the right to enforce the policy for same day cancellations.

Patient Signature: X_____ Date: _____

Witness Signature: X_____ Date: _____

625 Sixth Ave South ✦ St. Petersburg, FL 33701
Phone: (727) 896-4909 ✦ Fax: (727) 896-4901 ✦ Website: www.anuyouinstitute.com

New Client Form

Name: _____ **Reason For Visit:** _____

Date of Birth: _____ **Age:** _____ □ **Female** □ **Male**

Address: _____ **City:** _____

State: _____ **ZIP:** _____ **Email:** _____

Phone: Home #: _____ **Cell #:** _____ **Work #:** _____ **(√ preferred)**

Primary Care Physician: _____ **Approximate Date of Last Visit:** _____

PLEASE READ CAREFULLY AND EXPLAIN IN DETAIL ALL THAT APPLY

PAST MEDICAL HISTORY	YES √	NO √	EXPLAIN
Ears, Nose, and Throat Problems: Allergies, Ear Infections, Nasal Polyps, Tumors, Oral Ulcerations (Cold Sores), Sinus Problems, Sleep Apnea, Fainting			
Pulmonary (Lung) Problems: Asthma, Emphysema, Bronchitis, COPD, Frequent Colds, TB			
Cardiovascular Problems: Hypertension, Heart Failure, Palpitations, Pacemaker, Heart Attack, Blood Clots, Swollen Legs, Irregular Heartbeat, Syncope (Fainting)			
Endocrine/Infectious Disease Problems: Hormone Replacement, Diabetes, HIV, Hepatitis A B or C, Thyroid, Adrenal, Polycystic Ovarian Disease, Herpes			
Gastrointestinal Problems: Ulcers, Vomiting, Bloody Stools, Reflux, Diarrhea, IBS, Diverticulitis, Polyps, Liver or Kidney Failure			
Oncology Problems: Cancer (List Type), Chemo (Explain), Radiation (Explain), Last Visit (List Date) Are you in Remission?			
Ophthalmology (Eye) Problems: Glaucoma, Cataracts, Dry Eyes, Pink Eye, Lasik, Implants			
Rheumatology Problems: Arthritis, Lupus, Scleroderma			
Neurological Problems: Seizures, Palsy, Stroke, Weakness, Numbness, Muscular Dystrophy, Gillain-Barre, Multiple Sclerosis, Transient Ischemic Attack			

ALLERGIES: □ **NONE**

Please list any allergies to medications, (i.e. aspirin, lidocaine, hydrocortisone), food or latex:

_____

MEDICATIONS: □ **NONE**

Please list any medications (prescribed or over the counter) or herbs you are currently taking:

_____

TREATMENT/SURGICAL HISTORY: □ **NONE**

List surgeries, tattoos, permanent makeup, or skin treatments you have had, **INCLUDING LASER HAIR REMOVAL:**

_____

_____

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