Laser Skin & Wellness
Gloria Hakkaranen, MD

Wellness Intake Form

Name____ **Date**_________________

Address: ____

City: ____________________________ State: ________________ Zip: ______________

Phone number to contact you / leave a message: _______________________________
Is this your: Cell / Work / Home

Email: ____

How did you hear about us: ____

Birthdate ______/______/______ Gender M_______ F__________

Occupation: ____

Primary Care Physician ______________________Phone Number __________________

Pharmacy ________________________________Phone Number ___________________

What brought you to our office today____

This information is necessary. Please answer yes or no to the following questions:

YES **NO**

❑ ❑ Are you in good health at the present time?

❑ ❑ Are you using any prescribed medications?

If YES list dosage, and frequency____

____

❑ ❑ Are you using any Vitamins/Minerals medications?

List____

❑ ❑ Do you take oral blood thinning medications/supplements?

List ____

❑ ❑ Are you ***allergic*** to any cosmetic ingredients, medications, foods, environment?

List____

❑ ❑ Do you smoke? How much? ______________ How long?______________

FOR WOMEN:

First Period________ Pregnancies: Number_________ Natural Delivery or C-Section________

❑ ❑ Are you pregnant or trying to become pregnant? Last Check up______________

❑ ❑ Do you use oral contraceptives? Type__________________________________

❑ ❑ Do you use hormone replacement therapy? Type_________________________

Past Medical History:

[ ] High blood pressure
[ ] Heart disease
[ ] Diabetes (type)________
[ ] Hepatitis
[ ] Anemia
[ ] Leg or [ ] Lung blood clots
[ ] Sickle cell
[ ] Blood transfusions
[ ] Stroke
[ ] Bladder infections
[ ] Skin fungus
[ ] Bone fractures
[ ] Breast cancer
[ ] Sleep problems

[ ] Seizures
[ ] Sexually transmitted diseases
[ ] Uterine fibroids
[ ] Abnormal PAP smears
[ ] PMS
[ ] Genital Herpes or blisters
[ ] Oral Herpes or blisters
[ ] Osteoporosis
[ ] Endometriosis
[ ] Pneumonia
[ ] Kidney problems
[ ] PCOS
[ ] Cystic Acne
[ ] Glaucoma

[ ] Liver Disease
[ ] Depression
[ ] Psychiatric problems
[ ] Thyroid disease
[ ] Irritable bowel
[ ] Stomach ulcers
[ ] Arthritis
[ ] Headaches
[ ] Asthma
[ ] Autoimmune (lupus, scleroderma
[ ] Radiation treatment
[ ] Genital warts
[ ] Constipation

[ ] Skin cancer (type)______________________
[ ] Other cancer(type)__________________________
[ ] Other____

PastSurgeries____

____

Please check any mental health problems, current or past:

❑ Anxiety
❑ Alcoholism
❑ Anorexia
❑ Suicidal Thoughts
❑ Depressions

❑ Drug Addiction
❑ Bing Eating
❑ Suicidal Plans
❑ Bipolar Disorder
❑ Schizophrenia

❑ Bulimi
❑ Panic Attacks
❑ Nervous Breakdown

Please describe you general health goals and improvements you wish to make:

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❑ I certify that the above information is correct to the best of my knowledge.

Patient Signature____________________________________