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| --- | --- | --- |
| 2019 Annual Demographic, interest, & Physical exam form | | |
| Last Name | First Name | |
| Address City ST Zip | | |
| Age Date of Birth Cell Phone  Home Phone | | |
| PRINTED Email Address**\*  @** **.** | | **\*** Listing here constitutes permission  to Email Special Offers and Discounts |
| Occupation/Business: Married Divorced Widowed Single | | |
|  | | |
| |  |  |  | | --- | --- | --- | | **Interested In (check all that apply):**   * Facial Wrinkles/ Loose Skin * Lips: Thin or Uneven * Cellulite or Buttocks Shaping | **Interested In:**   * Face/Body: Scars * Skin: Sun Damage/Brown Spots * Skin: Large Pores | **Interested In:**   * Body Sculpting * Thinning Hair * Eyelash Growth | | | |
|  | | |
| **How did you hear about us? Circle ALL that apply:**   |  |  | | --- | --- | | Yelp Search Have Yelp App? Y N | Drive by or walk by | | Google Maps Have Gmail (email) Y N | Been here before / Email from Look Younger MD | | Google Botox/Juvederm Have Gmail? Y N | Friend’s Name: | | | |
|  | | |
|  | | |
| **Patient Signature Date** | | |

PE: For Office Use Only: Medical Assistant: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| ( ) VS: BP \_\_\_\_\_/\_\_\_\_\_ HR \_\_\_\_\_\_\_\_\_ HT \_\_\_\_\_\_ WT \_\_\_\_\_\_\_ TEMP \_\_\_\_\_.\_\_\_ |
| ( ) PE: YO (W B A H) M / F in NAD ( ) ABD: NT, no mass, +BS |
| ( ) HEENT: PERRLA NC/AT EOMI TMI B Post Pharynx Clear |
| ( ) CV: RRR w/o m/g/r ( ) Lungs: CTAB |
| ( ) Neuro: FROM, ~~O~~ NT, strength 4+/5 B (or \_\_+/5 \_\_ ) NVI, neg. Romberg |
| Comments: ( ) Follow up w/ PCP ASAP  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Patients for Cheek treatments:  Medrol Dose Pack (4 mg) #21, 5 refills. Use as directed.  Patients with “Cold Sores”:  Valtrex Tablets (1000 mg) ii po bid evening before Tx x 2 days #30, 5 refills |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Physician’s Signature Date |

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