BRIAN HUMPHREYS, M.D., F.A.C.S.

New Patient Information

Name:_____ Birth Date: _____/_____/_____ Age: _____
Address: _____ Sex: M / F
City: _____ State: _____ Zip Code: _____
Home: ( )_____ Work: ( )_____ Cell: ( )_____
E-mail: _____
Emergency Contact: _____ Telephone: ( ) _____
Allergies: _____
For Women: LMP: _____
How did you hear about ? _____

Please put a check mark next to the procedure about which you would like to receive more information:

___ Acne Treatment
___ Botox to Flatten and Prevent Wrinkles
___ Enhanced Skin Rejuvenation
___ Collagen Augmentation
___ Wrinkles
___ Skin Toning or Pore Size Reduction
___ Facial Redness
___ Brown Spots
___ Sun Damage
___ Broken Capillaries
___ Spider Veins/Leg Veins
___ Hair Reduction
___ Shaving bumps/ingrown hair
___ Restilyne

Please put a check mark next to a past or current medical condition:

Medical History:
___ Lupus or other auto-immune deficiency
___ Rheumatoid Arthritis "Gold" Therapy (A)
___ Currently Pregnant (A)
___ Bleeding abnormalities (A)
___ Treatment with Accutane® in the last year (A)
___ Treatment with Tetracycline® in the last year (A)
___ Keloid or very thick scarring (A)
___ Psoriasis or Vitiligo (A)
___ Pulmonary embolism/blood clot (V)
___ Leg ulcer or Phlebitis (V)
___ Blood thinning medication (V)
___ Coumadin/anti-clotting agents (A)
___ Cystic Acne (P)
___ Herpes simplex or fever blisters (A)
___ Diabetes (A)
___ Light sensitive Epilepsy (A)
___ Scars that turn white or brown (A)
___ Dark spots after pregnancy, skin injury (A)
___ HIV (A)
___ Hepatitis (A)
___ Waxing/Plucking/Electrolysis within last four weeks (HR)
___ Hirsutism (HR)
___ Transplant Anti-Rejection Drugs (HR)
___ Chemical Peels, Dermabrasion, Laser Resurfacing or Face Lift (A)
___ Tattoos/permanent make-up
___ Polycystic ovarian disease (PCOD)
___ Implants (Location: _____)
___ Collagen injection (Location: _____)

Please list any medications or herbal supplements that you are currently taking: