



Do you have, or have you ever had any of the following:

- | | | |
|--|--|---|
| <input type="checkbox"/> Skin Cancer | <input type="checkbox"/> Glasses | <input type="checkbox"/> Hemorrhoids |
| <input type="checkbox"/> Chronic Skin Infections | <input type="checkbox"/> Contact Lenses | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Sores That Do Not Heal | <input type="checkbox"/> Regular Eye Drop | <input type="checkbox"/> Excessive Anxiety |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Dry Eyes | <input type="checkbox"/> Excessive Depression |
| <input type="checkbox"/> Keloids or Bad Scars | <input type="checkbox"/> Visual Difficulty | <input type="checkbox"/> Excessive Fatigue |
| <input type="checkbox"/> Hepatitis/HIV | <input type="checkbox"/> Hearing Difficulty | <input type="checkbox"/> Suicidal Thoughts |
| <input type="checkbox"/> Blood Transfusion/Last 10 Years | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Psychiatric Care |
| <input type="checkbox"/> Jaundice | <input type="checkbox"/> Anemia | <input type="checkbox"/> Eating Problems |
| <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Asthma | <input type="checkbox"/> Difficulty With Anesthesia |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Frequent Cough | <input type="checkbox"/> Nausea After Surgery |
| <input type="checkbox"/> Heart Palpitations | <input type="checkbox"/> Herpes or Cold Sores | <input type="checkbox"/> Unexpected Social Status |
| <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Chronic Sore Throat | <input type="checkbox"/> Abnormal Lab Tests: |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Urinary Tract Infections | <input type="checkbox"/> Low Pain Tolerance |
| <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Thyroid Problems | <input type="checkbox"/> Easy Fainting |
| <input type="checkbox"/> Legs Clots or Embolus | <input type="checkbox"/> Severe Neck/Back Problems | |
| <input type="checkbox"/> Ankle Swelling | <input type="checkbox"/> Rheumatic or Scarlet Fever | |
| <input type="checkbox"/> Poor Leg Circulation | <input type="checkbox"/> Migraine or Headaches | |
| <input type="checkbox"/> Blood Clots In Legs | <input type="checkbox"/> Stomach ulcers or Heartburn | |
| <input type="checkbox"/> Easy Bleeding/Bruising | <input type="checkbox"/> Intestinal Bleeding/Ulcers | |

Are you taking any of the following?

- | | |
|---|--|
| <input type="checkbox"/> Antibiotics | <input type="checkbox"/> Blood Thinners |
| <input type="checkbox"/> Diet Pills | <input type="checkbox"/> Steroids |
| <input type="checkbox"/> Aspirin, Motrin, NSAIDS, or Cortisone | <input type="checkbox"/> Metformin, Glucophage, or Insulin |
| <input type="checkbox"/> Blood pressure or Heart Medicine or Water Pill use | <input type="checkbox"/> Herbal Supplements |
| <input type="checkbox"/> Birth Control Pills | <input type="checkbox"/> Hormone Supplements |
| <input type="checkbox"/> Other Recreational Drug Use | |

Are you allergic to any of the following? (List any that apply)

1. **Medications:** _____
2. **Foods:** _____
3. **Other:** _____

Please list any and all medications you are taking: (List any that apply)

1. **Prescription Medications:** _____

2. **Non-prescription Medications (including vitamins, aspirins, etc.):** _____

Patient Signature: _____ **Date:** ____ / ____ / ____



SKIN CONCERNS

Please check all the categories you may be interested in treating:

- | | |
|---|---|
| <input type="checkbox"/> Acne | <input type="checkbox"/> Lip Volumizing |
| <input type="checkbox"/> Acne Scarring | <input type="checkbox"/> Mole Removal |
| <input type="checkbox"/> Aging Skin | <input type="checkbox"/> Neck Rejuvenation |
| <input type="checkbox"/> Broken Capillaries / Blood Vessels | <input type="checkbox"/> Oily Skin |
| <input type="checkbox"/> Cellulite | <input type="checkbox"/> Permanent Makeup |
| <input type="checkbox"/> Chest / Décolletage Rejuvenation | <input type="checkbox"/> Pore Size |
| <input type="checkbox"/> Crow's Feet (Eyes) | <input type="checkbox"/> Restoration of Facial Volume |
| <input type="checkbox"/> Dry Skin | <input type="checkbox"/> Rosacea / Redness |
| <input type="checkbox"/> Eyebrow / Eyelash Treatments | <input type="checkbox"/> Scarring |
| <input type="checkbox"/> Excessive Underarm Sweat / MiraDry | <input type="checkbox"/> Skin Care Products |
| <input type="checkbox"/> Facial Veins | <input type="checkbox"/> Skin Rejuvenation |
| <input type="checkbox"/> Fat Reduction | <input type="checkbox"/> Skin Resurfacing |
| <input type="checkbox"/> Fine Lines | <input type="checkbox"/> Skin Tag Removal |
| <input type="checkbox"/> Forehead Creases | <input type="checkbox"/> Skin Tightening |
| <input type="checkbox"/> Freckles | <input type="checkbox"/> Smile Lines |
| <input type="checkbox"/> Frown Lines | <input type="checkbox"/> Stretch Marks |
| <input type="checkbox"/> Hair Removal | <input type="checkbox"/> Sun Damage / Brown Spots |
| <input type="checkbox"/> Hand Rejuvenation | <input type="checkbox"/> Texture Improvement |
| <input type="checkbox"/> Leg Veins / Spider Veins | <input type="checkbox"/> Under eye Issues |
| | <input type="checkbox"/> Wrinkle Elimination |

Other Interests: _____

Notes: _____



REFERRAL INFORMATION

Please let us know how you first heard about Dr. Hoefflin. (Please check one)

One of our patients: _____

Friend: _____

Another Doctor: _____

Online Search Engine(s) (i.e. Google or Yahoo): _____

Online: other site(s) (Please List): _____

Television: _____

Interview: _____

Other (Please Explain): _____

NOTICE TO CONSUMERS

Medical doctors are licensed and regulated by the Medical Board of California

(800) 633-2322

www.mbc.ca.gov

I acknowledge the above notice and understand that the physician is licensed and regulated by the board.

Patient Signature: _____ **Date:** ____ / ____ / ____