FALCONE CENTER
FUNCTIONAL, COSMETIC & INTEGRATIVE MEDICINE

PATIENT INFORMATION and HISTORY
(Please print and complete all four pages)

Full Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Date of Birth: _____/_____/_____ Marital Status: _____

Home #: _____Work #:_____ Cell #: _____

Email: _____

Occupation: _____

Emergency Contact: _____ Relationship: _____

Home #: _____ Cell #: _____

Pharmacy: _____ Number: _____

How may we contact you? (Check all that apply)

☐ Home Phone ☐ Cell Phone ☐ Work Phone ☐ Email ☐ Mail

Would you like to be added to our eblast list so that we can send your information regarding our monthly news, specials and events? YES NO

How did you hear about Dr. Falcone? _____

_____

☐ I hereby acknowledge that I have received a copy of the Notice of Privacy Practices
☐ I understand that any appointments not cancelled within 24 hours of the scheduled time are subject to a non-refundable $50 administration fee.

Patient Signature: _____

Print Name: _____

For Office Use Only:
If signed acknowledgement not received, document good faith efforts used to obtain:
_____

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MEDICAL HISTORY

Specific problem(s) for which you are seeking consultation _____

_____

Have you consulted any other doctors about this? ☐ YES ☐ NO

If yes, please list their names: _____

MEDICATIONS/DRUGS:

What is your approximate daily consumption of the following:

Coffee: _____ Tea: _____
Tobacco: _____ Alcohol: _____

Please list all medications you are now taking and their dosages, including birth control pills, diuretics (water pills), blood pressure or heart medications, tranquilizers, hormones, blood thinners, etc:

_____ _____ _____

_____ _____ _____

_____ _____ _____

MEDICAL/FAMILY HISTORY: Have you or has any relative had any of the following:

	YOU	RELATIVE		YOU	RELATIVE
Tuberculosis	☐	☐	Asthma	☐	☐
Diabetes	☐	☐	High Blood Pressure	☐	☐
Cancer	☐	☐	Blood or Bleeding Disorders	☐	☐
Heart Disease	☐	☐	Malignant Hyperthermia	☐	☐
Epilepsy	☐	☐	Mental Disease	☐	☐
Lung Disease	☐	☐	Other:	☐	☐
Kidney Disease	☐	☐	Other:	☐	☐

HEIGHT_____ WEIGHT_____ WEIGHT GAIN/LOSS IN PAST YEAR + / - _____ LBS.

Medical History (Check all that apply):

- ☐ Acne
- ☐ Artificial Heart Valves
- ☐ Artificial Joints
- ☐ Autoimmune Disease
- ☐ Bleeding disorders
- ☐ Blood Clotting
- ☐ Burns/skin grafts
- ☐ Botox
- ☐ Cancer
- ☐ Constipation
- ☐ Diabetes
- ☐ Eczema
- ☐ Endocrine disorders
- ☐ Keloid Scars
- ☐ Excessive Sweating
- ☐ Gold therapy
- ☐ Heart Defibrillator
- ☐ Heart Disease
- ☐ Herpes/Cold Sore
- ☐ High blood pressure
- ☐ Hirsutism
- ☐ History of Severe Allergic Reaction
- ☐ Hormone Replacement
- ☐ Immunosuppressive treatment
- ☐ Implants
- ☐ Lupus erythematosus
- ☐ Vascular Disease
- ☐ Metal Implants
- ☐ Permanent make-up
- ☐ Polycystic ovary disease
- ☐ Psoriasis
- ☐ Recent Weight Gain/Loss
- ☐ Rosacea
- ☐ Seizures
- ☐ Shingles
- ☐ Skin cancer
- ☐ Surgical Mesh
- ☐ Tattoos
- ☐ Thyroid disease
- ☐ Uterine Bleeding

☐ Other _____

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Name: _____

PREVIOUS SURGERIES (please list):

OPERATIONS	YEAR		SURGEON'S NAME	ANESTHESIA

1.) _____ ☐ LOCAL ☐ GENERAL

2.) _____ ☐ LOCAL ☐ GENERAL

3.) _____ ☐ LOCAL ☐ GENERAL

HAVE YOU HAD ANY SIGNIFICANT COMPLICATIONS OR AFTER EFFECTS FROM ANY OF THESE SURGERIES? ☐ YES ☐ NO
If YES, please explain:
_____

_____

Primary Care Physician: _____ Phone #: _____

Address:_____

Have you ever had any problem from general anesthesia?	☐ YES ☐ NO
Have you ever had a bad reaction to a local anesthetic (Novocain, Lidocain, etc)?	☐ YES ☐ NO
Are you allergic to adhesive tape?	☐ YES ☐ NO
Are you allergic to suture material, such as catgut?	☐ YES ☐ NO
Do you have high blood pressure?	☐ YES ☐ NO
Any history of blood clots, pulmonary emboli or phlebitis?	☐ YES ☐ NO
Have you ever had Scarlet Fever or Rheumatic Fever?	☐ YES ☐ NO
Do you stop bleeding quickly (from cuts, surgery, tooth extractions, etc)?	☐ YES ☐ NO
Have you had aspirin, Anacin, Motrin, Advil, Alka-Seltzer, etc in the last two weeks?	☐ YES ☐ NO
Do you form large scars or keloids?	☐ YES ☐ NO
Do you have any skin disease, hives, eczema or rash?	☐ YES ☐ NO
Do you have frequents infections or boils?	☐ YES ☐ NO
Do you have, or have you ever had, herpes or mouth sores?	☐ YES ☐ NO
Have you taken steroid medications, cortizone or ACTH?	☐ YES ☐ NO
Does your religion prohibit blood transfusions?	☐ YES ☐ NO
Do you have, or have you ever had, any significant emotional problems?	☐ YES ☐ NO
Have you ever had psychiatric care or been advised to see a psychiatrist?	☐ YES ☐ NO
Do you have any piercings that cannot be removed?	☐ YES ☐ NO

ARE YOU ALLERGIC TO ANY MEDICATIONS or Supplements? If the answer is YES, please list:

_____

Skin Allergies:
_____

Environmental Allergies:
_____

SIGNATURE:_____ DATE:_____

How long ago was your most recent physical checkup?_____
Examining Doctor:
_____

Did it include: Blood work? ☐ YES ☐ NO EKG? ☐ YES ☐ NO Chest X-ray? ☐ YES ☐ NO

List other illnesses (diabetes, high blood pressure, thyroid, etc).:_____

_____

Are you interested in any of our other treatments?

- ☐ Acne
- ☐ Acne Scars
- ☐ Age spots/ Brown Spots
- ☐ Natural Breast Augmentation
- ☐ Botox/Dysport
- ☐ Buttock Augmentation
- ☐ Cellulaze
- ☐ Cellulite Treatment
- ☐ Chemical Peels
- ☐ Clogged pores
- ☐ Dry Skin
- ☐ Enlarged Pores
- ☐ HCG Diet
- ☐ FaceLift
- ☐ Neograft Hair restoration
- ☐ Laser Hair Removal
- ☐ Liposuction
- ☐ Microdermabrasion
- ☐ Serotonin Plus Weight Loss
- ☐ Oily skin treatment
- ☐ Injectable Fillers
- ☐ Rosacea / Facial Redness
- ☐ Skin Laxity
- ☐ Skin Texture Improvement
- ☐ Spider vein Treatment
- ☐ Sun damage Treatment
- ☐ Underarm sweating
- ☐ Vampire Facelift
- ☐ Fat Transfer Procedures
- ☐ Medical Weight Loss
- ☐ Wrinkle Treatments
- ☐ Other _____

Are there any additional services you would like to discuss with our staff today?

_____

_____

Signature of Patient: _____ Date: _____

Signature of Consultant: _____ Date: _____

Reviewed by Clinician: _____ Date: _____

Reviewed by Dr. Victoria Falcone: _____ Date: _____