Atlantis Medical Wellness Center

Date: _____ Patient Name: _____ Date of Birth: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ E-Mail: _____

Employer: _____ Occupation: _____ Work Phone: _____

Person to contact in case of emergency: _____

Reason for consultation: _____ Are you currently under a physicians care? _____

Specify: _____

How Did You Hear About Us? (friend, website, specific ad, another physician): _____

HAVE YOU EVER BEEN DIAGNOSED WITH

	Yes	No		Yes	No		Yes	No
Diabetes	( )	( )	Heart Murmur	( )	( )	Phlebitis	( )	( )
Keliods	( )	( )	High Blood Pressure	( )	( )	Allergies	( )	( )
Thyroid disease	( )	( )	Bleeding Disorder	( )	( )	Hepatitis	( )	( )

DO YOU HAVE OR HAVE YOU EVER HAD ANY OF THE FOLLOWING CONDITIONS

	Yes	No		Yes	No
Herpes Simplex	( )	( )	Chemotherapy/Radiation	( )	( )
Smoke	( )	( )	Corneal Abrasions	( )	( )
Eye Lid injury	( )	( )	Blepharoplasty	( )	( )
Do you wear contacts	( )	( )	Tumors/Growths	( )	( )
Skin Cancer	( )	( )	Hyperpigmentation	( )	( )
Fainting/Dizzy spells	( )	( )	Circulatory problems	( )	( )

List all medications you are currently taking: _____
List any drug, make-up, food, and skin allergies: _____
Are you pregnant? _____ If so, how far along are you? _____
Have you ever been tested for HIV? _____ Results? _____
Do you have an immune disorder that would impair your healing process? _____
Are you prone to genital herpes breakouts? _____ Cold Sores? _____
Are you currently taking birth control pills? _____ Are you taking oral or injectable steroids? _____
If so, for what condition? _____
Is your skin type: Oily Normal Dry Sensitive Combination (Please circle)

In your own words, describe your health: _____

_____

What are you hoping to improve with your health? _____

Going back three generations, what is your family ancestry? _____

Patient signature: _____ Date: _____

OFFICE USE ONLY

_____
_____
_____
_____

Fitzpatrick Skin Test

Type I **Type II**

Type III **Type IV**

Type V **Type VI**