Main Line Center for Laser Surgery
32 Parking Plaza, Suite 200
Ardmore, PA 19003

NAME _____
(Last) (First) (Middle)
SS#_____ **BIRTHDATE**_____ **SEX: M F** **MARITAL STATUS: S M D W**

HOME ADDRESS _____
(Street) (Apt) (City) (State) (Zip)
HOME PHONE_____ **E-MAIL** _____

WORK PHONE_____ **CELL PHONE**_____

OCCUPATION_____ **EMPLOYER NAME**_____

REFERRED BY ☐*PHYSICIAN* ☐*FRIEND* ☐*INTERNET* ☐*OTHER*_____

EMERGENCY CONTACT_____ **RELATIONSHIP** _____ **PHONE#**_____

Specialized Care

I understand that the Main Line Center for Laser Surgery is a tertiary referral practice. The physicians at our center will evaluate the specific problem for which you have been referred or have sought treatment. General dermatologic care and evaluation is the responsibility of the referring or primary physician. If you require a referral to a general dermatologist, please notify our office.

_____
(Sign Name) **(Date)**

Reason for visit_____

Name of General Dermatologist_____

Have you ever been on Accutane? YES NO **If yes please also inform the doctor verbally. When?**_____

Do you have or have a history of **Cold Sores**? NO YES

Do you have or have a history of Scarring or Keloids? NO YES

Do/have you ever had permanent makeup/tattoos? NO YES If yes please also inform the doctor verbally

If yes where? Eyebrows Eyeliner Lip liner Other_____

Have you ever had Gold Therapy? NO YES If yes please also inform the doctor verbally

Are you pregnant at this time? NO YES

Do you faint when having blood drawn? NO YES

SOCIAL HISTORY: *(CHECK ALL THAT APPLY)*

Do you smoke? ☐ **NO** ☐ **YES - Frequency**_____ **Do you use recreational drugs?** ☐ **NO** ☐ **YES - Frequency**_____

DRUG ALLERGIES: *(LIST TYPE OF REACTION)*_____

NON-DRUG ALLERGIES: ☐ **LATEX** ☐ **OTHER** *(SPECIFY)*_____

PRESENT/PAST MEDICAL HISTORY: *(LIST CONDITIONS AND DATE)*

_____

ARE YOU CURRENTLY TAKING MEDICATION? ☐ **YES** ☐ **NO** **IF SO, PLEASE LIST:**_____

SURGICAL HISTORY: *(LIST TYPE, REASON FOR SURGERY, DATE, SURGEON)*

_____

PERSONAL or FAMILY HISTORY of MELANOMA? ☐ **YES** ☐ **NO** **WHO?**_____
CANCER(S): *(LIST TYPE, DATE, TREATMENT)*

_____

INFECTIOUS:____ HIV Positive ____ AIDS Virus ____ Hepatitis Other, specify_____

INTEGUMENTARY:____ Psoriasis____ Eczema ____ Cystic Acne____ Loss of Pigment Other, specify_____

MUSCULOSKELETAL:____ Arthritis____ Lupus____ Joint pain____ Joint replacement____ Cold sensitivity Other, specify_____

CARDIOVASCULAR:____ Stroke ____ Palpitation____ Pacemaker ____ High blood pressure Other, specify_____

NEUROLOGICAL:____ Headaches ____ Convulsions____ Seizures ____ Epilepsy____ Memory loss Other, specify_____

ALLERGIC/IMMUNOLOGIC:____ Asthma ____ Frequent infections____ Allergies____ Thyroiditis____ Vitiligo Other, specify_____

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OUR CANCELLATION POLICY

We do understand that there are times when you are unable to keep an appointment and need to reschedule. We ask that you kindly advise us at least 24 hours in advance. This will enable us to fill the appointment slot with someone from our wait list, and you will NOT be charged.

However, if you cancel an appointment within 24 hours or fail to show up for an appointment, you will be required to pay in full to make a future appointment. If you subsequently fail to provide adequate notice or fail to show up again, your payment will be held and NOT refunded and NOT put towards future appointments.

Thank you in advance for your cooperation.

_____ _____

Patient Signature Date