





**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)**

- Medications:** \_\_\_\_\_
- Foods:** \_\_\_\_\_
- Other:** \_\_\_\_\_

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

- Prescription Medications:** \_\_\_\_\_  
\_\_\_\_\_
- 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](http://www.mbc.ca.gov)

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

**Patient Signature:** \_\_\_\_\_ **Date:** \_\_\_\_ / \_\_\_\_ / \_\_\_\_