Rocky River Med Spa
The Fountain Clinic
19353 Detroit Rd
Rocky River, Ohio 44116
P: 216-600-5277 F: 216-600-5272
www.thefountainclinic.com

Phone (216) 503-8517

NEW PATIENT INFORMATION

Please Print

Fax (216) 503-8518

LAST NAME, FIRST NAME & MIDDLE INITIAL		DATE OF BIRTH	SOCIAL SECURITY NUMBER
STREET (& APT)			
CITY	STATE	ZIP	
E-MAIL		*May we use this e-mail to contact you?* ___YES ___NO	
HOME PHONE		WORK w/ extention - may we call you at work ___Yes ___No	
CELL		FAX	
OTHER		___Female ___Male	

EMERGENCY CONTACT INFORMATION

NAME			RELATIONSHIP
HOME PHONE	WORK w/ extention	CELL	OTHER

EMPLOYMENT INFORMATION

EMPLOYER
ADDRESS, CITY

GENERAL INFORMATION

MARITAL STATUS : ___ Divorced ___ Legally separated ___ Married ___ Single ___ Widowed ___Other

STUDENT STATUS CHECK ONE: ___ Non-student ___ Full time ___ Part time

How did you learn about our practice?

If you were referred, whom may we thank?

I AM RESPONSIBLE FOR THIS ACCOUNT.

Signature of Patient or Legal Guardian: X_____ **Date:** ___

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Skin Typing Matrix

Name: _____

Please answer the following questions by circling the number which best describes you. Your clinician will total your score during the consultation.

My ethnic origin is closest to:	Very fair (Celtic and Scandinavian)	☐
	Fair-skinned Caucasian with light hair and light eyes	☐
	Pale-skinned Caucasian with dark hair and dark eyes	☐
	Olive-skinned (Mediterranean, some Asian, some Hispanic)	☐
	Dark-skinned (Middle Eastern, Hispanic, Asians, some African)	☐
	Very dark-skinned (African)	☐
My eye color is:	Light blue	0
	Blue / Green	1
	Green / Gray / Golden	2
	Hazel / Light brown	3
	Brown	4
My natural hair color at age 18 was:	Red	0
	Blonde	1
	Light brown	2
	Dark brown	3
	Black	4
The color of my skin that is not normally exposed to sun is:	Pink to reddish	0
	Very Pale	1
	Pale with a beige tan	2
	Light brown	3
	Medium to dark brown	4
	Dark brown - black	5
If I go out into the sun for an hour or so without sunscreen and have not been out in the sun for weeks, my skin will:	Burn, blister and peel	0
	Burn, then when burn resolves there is little or no color change	1
	Burn, but then turns to tan in a few days	2
	Get pink, but then turns to tan quickly	3
	Just tan	4
	Just gets darker	5
	My skin color is so dark I can't tell	6
When was the last time the area to be treated was exposed to natural sunlight, tanning booths or artificial tanning cream?	Longer than one month ago	0
	Within the past month	1
	Within the past two weeks	2
	Within the past week	3

Total Score: _____

If your score is:	Your skin type is:
0 – 3	1
4 – 7	2
8 – 11	3
12 – 15	4
16 – 19	5
20 – 24	6

Additional skin response questions:

If you sustain an injury to your skin such as a cut, burn, or bruise, how long does it take to fully resolve without any hyperpigmentation? _____

What happens if you get an insect bite? _____

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MEDICAL HISTORY

PLEASE COMPLETE ALL **4** PAGES

Name :_____ **Date:** _____ Page 1

Your answers on this form will help us understand your medical concerns and conditions.
If you are uncomfortable with any question, do not answer it. Best estimates are fine, if you cannot remember specific details

AGE: _____ How would you rate your general health? Excellent Good Fair Poor

Present Health Concerns: _____

_____

_____

_____

Medications:

Prescription and non-prescription medicines, vitamins, home remedies, birth control pills, herbs:

Name of medicine	Dose	Times per day	When Started	Prescribed By:

Allergies or Reactions to Medications and Foods:

Medicine or food	Type of reactions	Year

Health Maintenance:

When were your most recent Screening tests:

Lipid (Cholesterol Screening) _____ Results? _____

Mammogram _____ Results? _____

Ever abnormal? _____ Details: _____

Pap Smear _____ Results?_____

Ever abnormal? _____ Details: _____

PSA (Prostate cancer screen) _____ Results? _____

Colonoscopy _____ Results? _____

Immumizations:

Hepatitis A _____ Hepatitis B _____ Influenza (Flu Shot) _____ Measles _____

Pneumovax (Pneumonia) _____Rubella _____ Tetanus (Td) _____

Varicella (chicken pox) shot _____or Illness ____

Personal Medical History:

Please indicate whether you have had any of the following medical problems (with dates):

___ Heart disease: specify type _____
___ Heart attack
___ High blood pressure
___ High cholesterol
___ Diabetes
___ Lightheadedness
___ Seizures
___ Thyroid problem specify type _____
___ Bleeding/clotting problem
___ Hepatitis or Jaundice
___ Abdominal pain or discomfort
___ Change in bowel habits
___ Ulcers
___ Blood transfusion
___ Kidney stones
___ Urinary frequency or urgency
___ Unexplained weight gain or loss
___ Cancer (Malignancy) specify type _____
___ Stroke or TIA
___ Asthma or reactive airway disease
___ Sexually transmitted diseases
___ Gout
___ Problems with alcohol
___ Problems with drugs
___ Depression

___ Chest pain/tightness
___ Palpitations
___ Shortness of breath
___ High triglycerides
___ Swollen ankles
___ Fainting
___ Frequent or severe headaches
___ Liver problems
___ Kidney problems
___ Gall Bladder disease
___ Blood in stool
___ Hemorrhoids
___ Colitis
___ Pneumonia
___ Persistant cough
___ TB
___ Eating disorder
___ Indigestion
___ Arthritis
___ Chronic neck or back problems
___ Impotence or erectile dysfunction
___ Loss of sexual interest
___ Loss of sexual response
___ Skin diseases or disorders
___ Suicide attempt

Other Problems

_____

Surgical History: Please list all prior operations (with dates):

_____

_____

Family History:

Social History:

Tobacco Use

Relative	Deceased Yes/No	If deceased, age of death, if not current age	If deceased, cause of death.	Health history, for example diabetes, heart disease, cancer, hypertension, high cholesterol, Alzheimer's, strokes, etc
Mother				
Maternal grandmother				
Maternal grandfather				
Father				
Paternal grandmother				
Paternal grandfather				

Cigarettes Never Quit: Date _____Current: Smoker: packs/day _____ # of yrs ____
Other Tobacco: Pipe Cigar Snuff Chew How many or how much per day_____
Are you interested in quitting? No Yes

Alcohol Use Do you drink alcohol? No Yes: # drinks/week _____
Is alcohol use a concern for you or others? No Yes

Drug Use
Do you use any recreational drugs? Yes No Have you ever used needles? Yes No

Sexual Activity
Sexually Active: Yes No Not Currently
Birth control method: _____ None needed
Have you ever had any sexually transmitted diseases (STDs)? No Yes

CAFFEINE Intake:
None Coffee/tea: _____ cups/day Sodas: _____ /day Chocolate: _____ oz./day

WEIGHT:
Are you satisfied with your weight? Yes No

DIET:
How do you rate your diet? Good Fair Poor

Name :_____ **Date:** _____

Diet, continued:
Do you take SUPPLEMENTS? _____
Do you eat or drink 3-4 serving of dairy products daily or take CALCIUM? Yes No

Exercise:
Do you exercise regularly? Yes No
What kind of exercise? _____
How long (minutes) _____ How often? _____
If you do not exercise, why? _____

Socioeconomics

Occupation: _____ Employer _____
Years of Education/Highest Degree _____
Marital status Single__ Married__ Widowed__ Divorced___ Separated__ Domestic Partner__
Spouse/Partner's name: _____
Number of children/ages:
_____

_____

Who lives at home with you? _____
_____

SPECIALTY HISTORY:

For women: # pregnancies: ____ # deliveries: ____ # abortions: ____ # miscarriages: ____
1st day, most recent period: _____ Age at 1st period: _____
Frequency of periods: _____ Length of each: _____
Do you have any concerns about your periods? Yes No
Do you have any concerns about menopause? Yes No

ANY OTHER INFORMATION WE SHOULD KNOW? YES NO

_____

_____

_____

Signature _____ Date _____