David M. Duffy, M.D. NEW PATIENT INFORMATION FORM

Date________________ Home Phone (______)____________ Email________________

Name______________________________ Age________ Date of Birth_____/_____/_____

Address____

Cell Phone (______)____________ Are you a former patient of Dr. Duffy's?________ If Yes, what year?________

Employer____________________ Occupation__________ Work Phone (______)________

Employer's Address____

Nearest Relative____________ Phone (______)__________ City, State____________

Do you have MediCare?________ MediCare#______________ Secondary Insurance Co. and #?____________

How did you find out about Dr. Duffy?____________________ Referred by:____________________

Medical History

Describe the reason for your visit today. Your problem? Where is it located? How long have you had it? Have you had treatment before for it? Are you currently using medication for it?

____

____

____

Are you currently under a physician's care for a **serious medical problem**? Describe____________________

Recent **surgeries or hospitalizations**? When? Describe____________________

List any **oral medications** you are currently taking.____________________

List any **allergies or reactions** to medications, either **topical or oral**.____________________

Have **you or any family member** had skin cancer, or other cancers, or cancer surgery?____________________

Have injuries to your skin ever healed with **raised scars, brown or white spots**? Describe.____________________

Do you have a history of any of the following conditions? **PLEASE CHECK ✔ ALL THAT APPLY.**

❑ Diabetes	❑ Heart Problems	❑ Seizures	❑ Epilepsy	❑ Fainting	❑ Irregular Heartbeat
❑ Tuberculosis	❑ High Blood Pressure	❑ High Cholesterol	❑ Hepatitis	❑ Jaundice	❑ Ulcers
❑ Gastric Disorders	❑ HIV Positive	❑ Respiratory Issues	❑ Hives	❑ Hay Fever	❑ Asthma
❑ Eczema	❑ Cold Sores	❑ Rashes	❑ OTHER____________		

Chronic skin problems (list)____

Serious Illnesses (list)____

Are you currently **pregnant or nursing**?______________ Do you plan to become pregnant?__________

Do you wear **contact lens**?________ Have you ever had an **adverse reaction to local anesthetic**?__________

For 30 years, Dr. Duffy's practice has been dedicated to cosmetic dermatology—the pursuit of healthier, more beautiful skin at any age. Because of this, we are happy to provide any information and services you desire on rejuvenating your skin. Please let us know if you have an interest in any of the following.

Other Items of Interest (OPTIONAL)

- ☐ Botox
- ☐ General Skin Rejuvenation
- ☐ Acne Breakouts
- ☐ Neck Rejuvenation
- ☐ Home Skin Care
- ☐ Rough Patches
- ☐ Silk Peels
- ☐ Hair Removal
- ☐ Tattoo Removal
- ☐ Lip Augmentation
- ☐ Wrinkles, Sun Damage
- ☐ FRAXEL Rejuvenation
- ☐ Hand Rejuvenation
- ☐ Sunscreen Advice
- ☐ Cracked Heels
- ☐ Rejuvenating Glycolic Peels
- ☐ Medical-Grade Facials
- ☐ Fillers
- ☐ Removing Unwanted Veins
- ☐ Irregular Pigment, Brown Spots
- ☐ Rosacea, Broken Veins on the Face
- ☐ Moles I'd Like Checked
- ☐ Liver Spots/Age Spots
- ☐ Loose Skin
- ☐ Resurfacing/Retexturizing
- ☐ Scars
- ☐ Other ______________________

Our website **www.drdavidmduffy.com** can provide you with lots of in depth answers to your questions, anytime you're ready.

<u>If we are treating you with any of the lasers today</u>, please read and respond to the Pre-Laser Treatment Questionnaire carefully. We will tailor the settings we use to treat you, based on the information you provide, so be as accurate as you can.

Pre-Laser Treatment Questionnaire

Have you used any of the following products on the areas to be treated today, in the past 5 to 7 days. Circle all that apply.

Product			Product		
Aspirin or Ibuprofen	YES	NO	Exfoliant Scrubs	YES	NO
Retin-A	YES	NO	Benzoyl Peroxide	YES	NO
Glycolic Products	YES	NO	Benzoyl Wash	YES	NO
Alpha Hydroxy Products	YES	NO	Chemical Peels	YES	NO
Anti-Acne Products	YES	NO	Shaved (in the past 2-3 days)	YES	NO
Anti-Wrinkle Products	YES	NO	Sun Exposure	YES	NO
Salicylic Acids	YES	NO	Suntan	YES	NO

______________________ Signature ____________ Date ____________ Staff Initials

David M. Duffy, M.D.
Practice Limited to Cosmetic and Dermatologic Surgery – Specializing in Sclerotherapy
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PATIENT QUESTIONNAIRE

1. Please list the family members or other persons, if any, with whom we may speak to regarding your care and treatment:

   ____

   ____

2. Please list the family members or significant others, if any, whom we may contact ONLY IN AN EMERGENCY:

   Name: ____________________ Phone Number: (____)____________
   Name: ____________________ Phone Number: (____)____________

3. Please print the address of where you would like follow-up correspondence from our office to be sent:

   ____

   ____

4. Please print the telephone number where you want to receive calls about your appointments, lab results, etc.: (______)______________________

   ***I am fully aware that a cell phone is not a secure and private line.**

5. Can messages regarding your appointments and follow-up visits be left on your telephone answering machine or voicemail?

   YES ______ NO ______

PATIENT NAME ________________________ (guardian if under 18 years)

____

PATIENT/GUARDIAN SIGNATURE DATE ______________

David M. Duffy, M.D.

Board Certified Experienced State-of-the-Art

Questionnaire for Energy-Based Modalities: Pelleve, Ulthera, etc.

Energy-based therapies are an excellent addition to our working tools for rejuvenating the skin. Used in conjunction with lasers, peels, fillers, neurorelaxants, etc., they confer an important and significant benefit in tightening the skin at a deeper level and rebuilding and strengthening its deep structure. Please take your time to answer our questions thoughtfully and **be sure to ask us any questions you might have.**

Name_________________________________ Best # to reach you after TX (_____)____________

Designated Driver________________________ Best # to reach them (_____)____________

Which of the following have you had in the past? **Check *all* that apply.**
Use the back of the form to give us the specifics (date, location) or tell us about other health issues

- ❑ metal plates in the neck or spine/joint replacements
- ❑ pacemaker or other cardiac appliances, screens
- ❑ dental implants
- ❑ replacement lens following cataract surgery
- ❑ chemotherapy
- ❑ thread lift (facial or other)
- ❑ laser treatments in the area we will treat
- ❑ fillers (Specify which/where)
- ❑ Botox
- ❑ previous treatments with Thermage or Titan
- ❑ Issues with pigmentation (melasma, vitiligo)
- ❑ Neurological issues (epilepsy, stroke, seizures)
- ❑ Clotting disorders
- ❑ Muscle tics
- ❑ Vascularization issues (Rosacea, Poikiloderma)
- ❑ Skin disease (psoriasis, lichen planas)
- ❑ Herpes
- ❑ Frequent Synus infections
- ❑ Autoimmune disease (Lupus, etc)
- ❑ Allergies (specify)
- ❑ Are you pregnant or trying to become pregnant
- ❑ cochlear ear implants
- ❑ allergic to corn or eucalyptus
- ❑ active cystic Acne
- ❑ disease affecting connective tissue
- ❑ regular use of Aspirin, Warfarin, etc.
- ❑ regular use of anti-inflammatory meds
  Advil, Motrin, Alleve, Celebrex
- ❑ use of Retin-A, salicylic, glycolic acid
- ❑ Use of Acutane
- ❑ ________________________________
- ❑ ________________________________

Signature____________________________________date_________________________

A Medical Practice Dedicated to Healthier, More Beautiful Skin At Any Age

- The Latest Therapies for Wrinkles, Sun Damage, Acne and Scars
- Laser Treatments and Resurfacing
- Vein Treatment is our Specialty for over 30 years
- Dermal Fillers
- Botox/Neurorelaxants
- FRAXEL
- Energy-Based Therapies... Pelleve, Ulthera
- SILK PEEL
- Rejuvenating Peels
- Intense Pulsed Light Photo Rejuvenation
- Photodynamic BLU-U Light Therapy
- Hand Rejuvenation
- Tattoo Removal
- Selected Home Care Preparations

PLEASE USE THIS SPACE TO PROVIDE THE **SPECIFICS ABOUT ANY ITEMS YOU CHECKED ON THE FIRST PAGE.**

PLEASE USE THIS SPACE TO **TELL US ABOUT ANY OTHER HEALTH ISSUES YOU MAY HAVE.**

Other health issues ____________________