Submit To IMP Wellness

Print and Sign

INTERNAL MEDICINE & PEDIATRICS WELLNESS CENTER
6038 W. Nordling Loop, Crystal River, FL 34429
Ph: (352) 563-5070 Fax (352) 795-4322

NAME:_____ TODAY'S DATE:_____/_____/_____
Last First Month Day Year

ADDRESS:_____ BIRTH DATE:_____/_____/_____
Month Day Year

CITY: _____ STATE:_____ ZIP CODE: _____

Best phone number to contact you regarding your treatment and where we may leaave a message:

HOME PHONE: ( ) _____ CELL PHONE: ( ) _____ WORK PHONE: ( ) _____

VIP E-MAIL: _____ How did you hear about us?_____

Primary Care Physician:_____ PCP PHONE NUMBER: _____

Please tell us your main concerns that brought you to our office today:

This information is necessary for your procedure. Please answer yes or no to the following questions:

YES	NO	
○	○	Are you using any prescribed medications? List_____
○	○	Are you using any herbal medications? List _____
○	○	Do you take oral anti_coagulant (Blood Thining) medication? List:_____
○	○	Are you alergic to any cosmetic ingredients, medications or foods? List:

○	○	Are you pregnant or trying to become pregnant?
○	○	Do you use oral contraceptives?
○	○	Do you use hormone replacement therapy?
○	○	Do you smoke? How much?_____How long? _____
○	○	Do you spend a lot of time outdoors or use a tanning bed often?
○	○	Do you have any tatoos or permanent makeup?

Please check any health problems, past or present:

- ☐ Seizures
- ☐ Liver Disease
- ☐ Skin Cancer (Type:_____)
- ☐ Hormonal Problems
- ☐ Diabetes
- ☐ Cystic Acne
- ☐ Thyroid
- ☐ High Blood Pressure
- ☐ Heart Problems
- ☐ Collagen (Lupus)
- ☐ Sarcoidosis
- ☐ Hepatitis
- ☐ Vasovagal Syncope
- ☐ PCOS
- ☐ Autoimmune (Lupus, scleroderma)
- ☐ Cancer
- ☐ Asthma

Do you have any of the following chronic skin disporders?

- ☐ Psoriasis
- ☐ Dermatitis
- ☐ Exzema
- ☐ Keloid Scarring
- ☐ Fever Blisters
- ☐ Cold Sores
- ☐ Sun Blisters
- ☐ Herpes Simplex/Blisters