HARRINGTON
+ ASSOCIATES

PATIENT STICKER

HISTORY INTAKE FORM

Patient Name: ____ **Birth Date:** _____________________
Address: ____ **Phone#:** _________________________
City: ____________________________ **State:** _______ **Zip:** _____________
E-mail: ____

Please answer all of the following questions as accurately as possible.

Reason for your visit:

____

How did you hear about us? ____
Smoking (type & frequency)__________________ **Alcohol** (drinks per week) _______________
If former smoker, quit date: ___________________ **Weight**: _____________ **Height:** ____________
Exercise (type and frequency): _______________________________**Weight stable?** _____________
Occupation:

____

Drug allergies:

____

List any ongoing chronic illnesses: ____
List previous surgeries:

____

Problems with anesthesia? ____
Current medications:

____

Medical History

Do you have a bleeding problem? Yes … No
Ever experienced a blood clot? Yes … No
Do you have sleep apnea? Yes … No
Do you have diabetes? Yes … No
Are you pregnant or nursing? Yes … No
Family Illness History:

____

Wear glasses? Yes … No
Wear contacts? Yes … No
Mole Concerns? Yes … No
Lasik Surgery? Yes … No

Are you interested in information regarding our wellness program for Hormone Balancing or HCG Weight Loss? Yes … No
Are you interested in information regarding Botox/Dysport, Dermal Fillers, CoolSculpting, Thermiva, Cellfina? (Circle which)

Women Only

Bra size: ___________ Last mammogram date and results: _____________________ Num. of children: ___________ Family history of breast cancer? ____
Are you unhappy with your breasts? If yes, why: ____
Do you think your breasts are symmetric? ____

I VERIFY THAT THE ABOVE INFORMATION PROVIDED IS ACCURATE TO THE BEST OF MY KNOWLEDGE.

Patient Signature:____ DATE: _______________________