

PLEXR Plasma Intake Form



Patient Information

Name		Date of Birth
Address		
City	State	Zip Code
Phone #	Email	
Occupation		
Emergency Contact Name		Phone #
How did you hear about us?		

Medical History

Please check all that apply:

- | | | |
|--|--|--|
| <input type="checkbox"/> Alopecia | <input type="checkbox"/> Eczema | <input type="checkbox"/> Kidney Disease |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Laser Eye Surgery |
| <input type="checkbox"/> Asthma/COPD/Emphysema | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Liver Disease |
| <input type="checkbox"/> Autoimmune Disease | <input type="checkbox"/> HIV/Aids | <input type="checkbox"/> Pacemaker/Electronic Device Implant |
| <input type="checkbox"/> Bleeding Disorder | <input type="checkbox"/> Hives/Herpes/Shingles | <input type="checkbox"/> Pregnant/Breastfeeding |
| <input type="checkbox"/> Blood Disorder/Hemophilia | <input type="checkbox"/> Hyper/Hypo-Pigmentation | <input type="checkbox"/> Recent Surgical Incision |
| <input type="checkbox"/> Blood Thinners/Anticoagulants | <input type="checkbox"/> Hypertension | <input type="checkbox"/> Rosacea |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Infection | <input type="checkbox"/> Transdermal Drug Delivery System |
| <input type="checkbox"/> Cataracts | <input type="checkbox"/> Insulin Monitor | <input type="checkbox"/> Thyroid Disorder/Disease |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Keloid Scarring | <input type="checkbox"/> Other _____ |

If you suffer from any of the above it is important that you notify your Practitioner who can take the necessary precaution to ensure you receive the best treatment to avoid any risks to your health.

Do you have any other allergies? Yes No

If yes, please list:

Are you currently on any blood-thinning prescription or non-prescription drugs? Yes No

If yes, what kind?

Are you currently taking any medications? Yes No

If yes, what kind?

Do you have any other medical conditions not listed above? Yes No

If yes, what kind?

Do you use recreational drugs? Yes No

If yes, what kind?

Have you used Accutane in the last 12 months? Yes No

Have you used Retin-A, Renova, glycolic acid, AHAs or Retinal products in the last three months? Yes No

If yes, please explain:

Do you have any birth marks, port-wine stains, or cosmetic tattoos? Yes No

If yes, where?

Have you received any skin tightening treatment before? Yes No

(If "Yes" please answer the following questions:)

How long ago was your treatment?

What procedure did you receive?

Where did you receive the treatment?

Where you happy with the result? If no, please explain the reasons why. Yes No

If no, please explain the reasons why:

Do you have or are you planning to have any injectables, fillers or chemical peels in the near future? Yes No

By signing below, I agree to the following:

I have completed this form to the best of my ability and knowledge. I understand the importance of my accurate and complete medical history. I understand that withholding any medical information may be detrimental to my health and safety during and after the procedure. I understand that if there is any change in my medical history it is my responsibility to inform my practitioner. I agree to inform the practitioner of any changes in the above information. I agree that I do not have any condition(s) that would make the requested treatment unsuitable. I will inform the practitioner of any discomfort I may experience at any time during my treatment to allow them to adjust accordingly. I agree to waive all liability toward my practitioner and Johnsons Family Medicine for any injury or damages incurred due to any misrepresentation of my health.

Patient Name

Signature

Date

Provider Name

Signature

Date