Laser Nail Treatment and Medical History

Last Name:______________________________First Name:________________________________ M.I.:______
Gender: [ ] F [ ] M DOB:_________/__________/__________ SSN: ________________________________
Home Phone: (________) _______________________ Cell Phone: (________) ___________________________
Address:________________________________ City:______________________ State:________ Zip:__________
Email Address: ____
Emergency Contact:____ Phone:_____________________________
Relationship: ____
How did you hear about our clinic? _________________________ Primary care doctor:______________________
Name of preferred pharmacy:__________________________ Pharmacy phone number:______________________
Preferred language:____ Hispanic: [ ] Yes [ ] No [ ] Abstain

1. Are you here today for a Nail Fungus problem? [ ] Yes [ ] No **(If "no" skip to question 5)**
2. How long have you had this problem? __________________(Months) (Years)
3. Has this condition been treated before? [ ] Yes [ ] No
4. Check all treatments that you have used or tried:

[ ] Anti-fungal Pills: How long? ________ Last time used: _________
[ ] Topical Anti-fungals: How long? ________ Last time used: _________
[ ] Laser Nail Treatment: How long? ________ Last time used: _________
[ ] Home Treatments (i.e. Tea Tree): How long? ________ Last time used: _________
[ ] Other: Type______________________ How long? ________ Last time used: _________

5. Do you have any of the following conditions? (Circle all that apply to you) [ ] None

Diabetes Heart Disease High Blood Pressure Numbness Stroke
Easy Bleeding Psoriasis Cancer Peripheral Vascular Disease
Other:____

6. Smoking status: [ ] Previously [ ] Currently [ ] Never
7. Are you currently pregnant? [ ] Yes [ ] No
8. List any medications you are now taking: [ ] None

____
____

9. List any medications you are allergic to: [ ] None

____

10. Do you get pedicures at Nail Salons? [ ] Yes [ ] No If "yes", how often? _______________________________

Name of salon:____

11. What is your occupation/ work environment?

____

12. What size shoes do you wear?

____

13. What type of shoes do you wear?

____

14. Do you have any other foot problems? [ ] Yes [ ] No If "yes", please describe below.

____

Please initial each of the following lines and sign the line at the bottom of the page. Thank you.

_________ I acknowledged that I have received the "Electronic Correspondence Information".

_________ I acknowledged that I have received the "Notice of Information Practices and Privacy Statement".

_________ I acknowledged that I have received the "Informed Consent" form; as indicated by my initials here and signature below, I hereby acknowledge that I am consenting to be treated by Dr. Lee Keenen, DPM.

I acknowledge that I have read and fully understand the above mentioned documents. I understand the risks associated, and consent to the conditions and post treatment guidelines.

____
Patient's signature/Authorized Individual Date