GARY A. KNIGHTON, D.O.

Patient History Form

PATIENT NAME:_____ AGE:_____ D.O.B. _____/_____/_____

CURRENT MEDICATIONS:_____

MEDICATION ALLERGIES:_____

BLOOD TYPE: _____ If you don't know, we will type you at your appointment today.

History of Bariatric Surgery? Y / N If yes, please explain: _____

_____

Do you smoke? Y / N If yes, how much and how long? _____

Do you drink alcohol? Y / N If yes, how much and how long? _____

Do you have a history of addiction? Y / N

Do you have a history of an eating disorder? Y / N

IS THERE A FAMILY OR PERSONAL HISTORY OF ANY OF THE FOLLOWING?

	FAMILY	PERSONAL		FAMILY	PERSONAL
Arthritis	_____	_____			
Osteoporosis	_____	_____	Seizures/Epilepsy	_____	_____
High Blood Pressure	_____	_____	Kidney/Bladder Problems	_____	_____
Heart Disease	_____	_____	Chronic Fatigue	_____	_____
Heart Attack	_____	_____	Frequent Headaches	_____	_____
Pacemaker	_____	_____	Hormone Imbalance	_____	_____
High Cholesterol	_____	_____	Food Allergies	_____	_____
Liver Disease	_____	_____	Asthma	_____	_____
Diabetes	_____	_____	Fibromyalgia	_____	_____
Anemia	_____	_____	Polycystic Ovaries (PCOS)	_____	_____
Depression	_____	_____	Recent Weight Loss/Gain	_____	_____
Anxiety	_____	_____	Thyroid Problems	_____	_____
Swelling in Ankles	_____	_____	Obesity	_____	_____

Other:_____

If you answered "yes" to any of the above, please explain below:

_____

_____

_____

FOR OFFICE USE ONLY: VERIFY ADDRESS? **YES** **NO**

VERIFY CONTACT PHONE NUMBER? **YES** **NO**

VERIFIED ON: _____/_____/_____ BY_____ (STAFF INITIALS)

Please list any and all surgeries (including cosmetic) and the dates: _____

_____

_____

Please list any complications to the surgeries, if any:_____

_____

Name of your family/primary care physician:_____

Date of your last physical examination:_____

FEMALES ONLY

Do you get regular PAP smears? Y / N
Do you get regular breast exams and mammograms (if needed)? Y / N
Do you use Birth Control? Y / N If yes, what form? _____
Is there any chance you might be pregnant? Y / N

MALES ONLY

Do you get yearly physicals to include prostate examinations? Y / N

Primary Care Physician:_____

Other Physicians you see:_____

The information above is correct to the best of my knowledge:

_____ _____/_____/_____
Patient/Parent/Guardian Signature Date

GARY A. KNIGHTON, D.O.

Last Name:_____ First Name:_____ M.I.:_____

Date of Birth:_____/_____/_____ Social Security #:_____-_____-_____

Address:_____City:_____State:_____Zip:_____

Email Address: _____

Male / Female Single / Married / Divorced / Widowed

Phone Number: (_____) _____-_____ Alternate Number: (_____) _____-_____

Employers Name: _____ Phone Number: (_____) _____-_____

Employers Address: _____ City:_____ State:_____ Zip:_____

Person(s) we may contact in an emergency:

Name:_____ Phone number: (_____) _____-_____

Name: _____ Phone number: (_____) _____-_____

How did you hear about our office? (Please circle all that apply)

Friend Movie Theater

Internet /Website Doctor:_____ Other:_____

OFFICE USE ONLY: NEW PATIENT RESTART_____YEAR UPDATED INFO DATE:_____/_____/_____ STAFF INITIALS:_____

GARY A. KNIGHTON, D.O.

SKINSATIONAL AESTHETICS OF ARIZONA

2152 S Vineyard, Ste 135

Mesa, AZ 85210

I, _____, CERTIFY THAT I AM NOT PREGNANT
(PLEASE PRINT: FIRST & LAST NAME)

AT THIS TIME, AND IF I DO BECOME PREGNANT I WILL IMMEDIATELY NOTIFY DR. KNIGHTON.

_____ ____/____/____

PATIENT SIGNATURE DATE

_____ ____/____/____

WITNESS DATE