all about you
DR. CHRISTINE GOULD MED SPA

New Patient History Form

Date_____ *(for Dr. Gould - Skin type_____)*
Name:_____ Age_____
Date of Birth:_____Weight:_____Height_____ BMI____
Phone: H_____ W_____ C_____
Cell phone carrier(for confirmations)_____
Email_____
Address:_____
_____
What is the best way to contact you?_____
Emergency Contact_____
phone_____
Relationship_____ permission to contact in emergency_____(initial)

What would you like to discuss today?_____
Past medical/surgical history_____
_____
Allergies_____
Medications_____
Vitamins_____
Are you a smoker?_____Last menstrual period_____ Menopause: Y N
Are you currently optimizing your hormones?_____How?_____
List any pertinent medical issues you may have_____
How do you rate your overall health?_____
Please describe your diet & exercise routine_____
Previous Aesthetic Treatments & Satisfaction_____
_____
List any concerns you may have_____
How did you find out about us?_____

Payment due at time of service
Photo ID required

Options: ***please check***
Cash/Check save 3%_____
Debit card - 3% fee (over $1000)_____
Care Credit - 6% fee_____