2022 ANNUAL DEMOGRAPHIC, INTEREST, & PHYSICAL EXAM FORM

Last Name | First Name

Address | City | ST | Zip

Age | Date of Birth | Cell Phone | Home Phone

PRINTED Email Address* @ . * *Listing here constitutes permission to Email Special Offers and Discounts*

Occupation/Business: Married Divorced Widowed Single

Music _____ **Snacks** _____ **Drink**_____

Interested In (check all that apply):		
❑ Facial Wrinkles/ Loose Skin	❑ Face/Body: Scars	❑ Skin: Sun Damage/Brown Spots
❑ Lips: Thin or Uneven	❑ Skin: Large Pores	❑ Urinary Incontinence / Orgasms

1) How much time each day do you spend thinking about how you look? a) <1 Hour b) 1-3 Hours c) >3 Hours
2) How much has this concern about how you look affected your life? a) Mild b) Moderate c) Severe
3) How many previous Physicians, Nurses, or PAs have you been to for this same condition? _____
4) What percent improvement is the **minimum** you expect? 30% 40% 50% 60% 70% 80% 90% 100%

How did you hear about us? Circle ALL that apply:

Yelp Search	Have Yelp App? Y N	Drive by or walk by
Google Maps	Have Gmail (email) Y N	Been here before / Email from Look Younger MD
Google Botox/Juvederm	Have Gmail? Y N	Referred--Friend's Name:

I hereby acknowledge that my consultation today is no guarantee of treatment if referral elsewhere is recommended. I also agree to document my results by photography and will make no objection of any kind or in any medium if we believe your needs will be better met elsewhere.

Patient Signature ***Date***

PE: For Office Use Only: Medical Assistant: _____

( ) VS: BP _____/_____ HR _____ HT _____ WT _____ TEMP _____.___

( ) PE: YO (W B A H) M / F in NAD ( ) ABD: NT, no mass, +BS

( ) HEENT: PERRLA NC/AT EOMI TMI B Post Pharynx Clear

( ) CV: RRR w/o m/g/r ( ) Lungs: CTAB

( ) Neuro: FROM, ~~O~~ NT, strength 4+/5 B (or __+/5 __) NVI, neg. Romberg

Comments:
( ) Follow up w/ PCP ASAP ( ) Follow up w/Plastic Surgery ( ) Follow up w/_____

For Cheek, Lips, and Large Volume: ☐ Medrol Dose Pack (4 mg) #21, 5 refills. Use as directed Date: _____
"Cold Sores": ☐ Valtrex Tablets (1000 mg) ii po bid evening before Tx x 2 days #30, 5 refills Date: _____

_____
Physician's Signature Date