



**ALICIA BARBA, M.D., PA**

**PLEASE FILL OUT BOTH SIDES COMPLETELY**

**Patient Name** \_\_\_\_\_ **Age:** \_\_\_\_\_ **Date:** \_\_\_\_\_

Reason for today's visit \_\_\_\_\_

Where is the problem located? \_\_\_\_\_ When did it start? \_\_\_\_\_

What symptoms are you having? \_\_\_\_\_ Severity:  Mild  Moderate  Severe

What makes condition better or worse? \_\_\_\_\_

What medications have you used? \_\_\_\_\_

Please list all the Prescription and Non prescription Medications that you are currently taking:

NONE \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Do you have any allergies to medicines?** Y N **If Yes, Please list:** \_\_\_\_\_

**PAST MEDICAL HISTORY:**  **NONE. I Am Healthy**

Psoriasis  Eczema/Dermatitis  Acne  Skin Cancer: **Where and What type?** \_\_\_\_\_  
 Other Skin Problem: \_\_\_\_\_

**Lungs**

Bronchitis  Emphysema  Asthma  Chronic Cough  Morning Cough

**Vascular**

High Blood Pressure  Chest Pain  Heart Attack  Irregular Heartbeat  Blood thinners  
 Pacemaker  Blood Clots/Phlebitis  Bleeding problem  Heart Murmur

**Other Systemic**

Diabetes  Thyroid  Kidney  Bladder  Stomach  
 Bowel  Hepatitis B or C  Glaucoma  Arthritis/Joint  HIV

**Do you have artificial joints?** Y N **If yes, please list** \_\_\_\_\_

Other Medical Problems that we should be aware of? \_\_\_\_\_

**FAMILY HISTORY:**

Are there any diseases that run in your family? Y N **If yes, please list** \_\_\_\_\_

**Please answer the following questions**

Do you take antibiotics for dental procedures? Y N **If yes, why?** \_\_\_\_\_  
Do you drink alcohol? Y N **If yes, how much?** \_\_\_\_\_  
Do you smoke? Y N **Packs per day** \_\_\_\_\_  
Are you allergic to local anesthesia? Y N  
Are you latex intolerant or allergic? Y N **Please let staff know if you are latex allergic**  
Is there anything else that we should be aware of? Y N \_\_\_\_\_

**Women Only**

Are you pregnant? Y N  
Are you trying to become pregnant? Y N  
Are you breast feeding? Y N

**Women: If you answered yes to these questions, please let Dr. Barba and the staff know!**

**Review of Systems:**

Are you currently having trouble with any of the following organ systems:

**If Yes, Please describe:**

Eyes	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Ears/ Nose/ Throat/ Mouth	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Heart	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Lungs	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Stomach/ Bowel	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Kidneys	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Arthritis/ Muscles/ Joints	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Headaches/ Seizures	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Psychological disorder	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Endocrine/ Hormonal	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Fever/ Chills	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____

Patient Signature: \_\_\_\_\_ DATE \_\_\_\_\_

Reviewed by Dr. Barba

**WE OFFER A FULL RANGE OF COSMETIC PROCEDURES  
THESE PROCEDURES ARE NOT COVERED BY INSURANCE**

**PLEASE CIRCLE ANY OF THE FOLLOWING PROCEDURES THAT YOU WOULD LIKE  
TO DISCUSS WITH DR. BARBA**

BOTOX

SCLEROTHERAPY FOR LEG VEINS

MICRODERMABRASION

LIP AUGMENTATION

RESTITYLANE FILLER FOR WRINKLES

PERLANE FILLER FOR DEEP WRINKLES

HYLAFORM FILLER FOR WRINKLES

LASER HAIR REDUCTION

ELECTROLYSIS FOR PERMANENT HAIR REMOVAL

FACIALS FOR MEN AND WOMEN  
Deep Pore Cleansing Facial

LASER TREATMENT OF BLOOD VESSELS

COLLAGEN

EARLOBE REPAIR

GROWTH REMOVAL

AGE (BROWN) SPOTS ON HANDS, ARMS, CHEST

CHEMICAL PEELS FOR SKIN  
PIGMENTATION/ MELASMA

ANTI AGING SKIN CARE PRODUCTS