OPTIMIZATION CENTRE™
Life Optimal. From The Outside In.
3010 N. Military Trail, Suite 200 Boca Raton, FL 33431
561.495.2700 | www.optimizationcentre.com

PATIENT #:_____
Date: ___/___/___

DEMOGRAPHIC INFORMATION: PLEASE PRINT: (*All areas of this form are required to receive a proper evaluation*)

First Name: _____ Middle Name: _____ Last Name: _____

How do you like to be addressed (circle one)? Dr. Mr. Mrs. Miss Other:_____

Address: _____ Apt: _____ City :_____ State: _____ Zip: _____

SSN: _____ DOB: _____ Age: _____ Marital Status: _____ Gender: Female Male Transgender

Home Phone: _____ Cell Phone: _____

E-Mail: _____ Occupation: _____

If a Minor, Guardian Name: _____ Relationship: _____ Contact Number: _____

How did you hear about Dr. Albert's Optimization Centre:_____

MEDICAL INFORMATION:

Medical Allergies: (*List & State Reaction*)

_____
_____
_____

Current Medications/Supplements: (*List Name & Dosage*)

_____
_____
_____

Height: _____ **Weight:**_____

Social History: (Circle & Fill In)

Tobacco? ◻ Cigarettes/Cigars ◻ Chew ◻ Pipe ◻Never

Quit (date): _____

Caffeine? ◻ Never ◻ coffee/tea/soda

Alcohol? ◻ Never ◻ Rarely ◻ Social ◻ Daily

Recreational drugs? ◻ Yes ◻ No

Pharmacy Name & Number: _____

Medical History: *Do you have, or have you had history of this condition? (Mark all that apply)*

◻ Heart Disease	◻ Lung Disease	◻ Kidney Disease	◻ Liver Disease	◻ Thyroid Disease	◻ Bone/Joint Disease
◻ High Blood Pressure	◻ Low Blood Pressure	◻ Heart Attack	◻ Asthma	◻ Diabetes	◻ Arthritis
◻ Bruise/Bleed Easily	◻ Stroke	◻ Anemia	◻ Epilepsy	◻ Immune Deficiency	◻ Rheumatism
◻ Scarlet Fever	◻ Hay Fever	◻ Headaches	◻ Glaucoma	◻ Cold sores	◻ Herpes
◻ Skin Rashes	◻ Depression	◻ Alcoholism	◻ Cancer: Specific:		
◻ HIV	◻ Hepatitis A, B	◻ Hepatitis C	◻ Other :_____		

Has anyone in your family had any of the mentioned conditions above? **Yes** **No** If Yes Whom:_____

Women's Health History:

Pregnancies: _____ Deliveries: _____ Currently Breast Feeding: Yes No

Date of Last Mammogram: _____ Results: _____

Surgical History: List any previous surgeries

Type:_____ Dr._____ Date:_____ Side effects:_____

Type:_____ Dr._____ Date:_____ Side effects:_____

Type:_____ Dr._____ Date:_____ Side effects:_____

HIPAA PRIVACY POLICY & PHYSICIANS RELEASE: In compliance with the Federal Government we endorse the patient privacy act. This act, also known as HIPAA, ensures your medical record safety, but also inhibits us from obtaining essential medical information that may affect your procedure(s)/care. This release gives our office the permission to acquire and distribute your testing and medical information. These records are shared only with essential medical personnel and the hospitals or surgical centers in which Dr. Albert is staffed. Without this release we are unable to perform any procedure(s).

AMERICAN SOCIETY OF PLASTIC SURGEONS

MEDICAL

X **Patient Signature:**_____

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COSMETIC QUESTIONNAIRE

OFFICE FINANCIAL POLICY: The patient is responsible for any and all charges incurred under the medical care of Gregory Albert, M.D., P.A. By signing this policy I hereby waive my right to dispute a credit card charge for services rendered. There are absolutely no refunds for product(s) or service(s)

Name: _____

What is the reason for your visit today? _____

Our mission is to collaborate with you to determine the best procedures and services to deliver your optimal life transformation. We designed the following questionnaire to help us reveal each patient's unique aesthetic goals.

When looking at myself in the mirror:	**Disagree** →			**Agree**
I have areas I wish to improvement	1	2	3	4	5
I believe I look my true age	1	2	3	4	5
I am concerned about the appearance of my skin	1	2	3	4	5
I am pleased with the shape of my body	1	2	3	4	5

I am concerned about (please check all that apply):

☐ Lines around my Eyes/Forehead
☐ Lines by Nose/Mouth
☐ Looking Tired
☐ Thin Lips
☐ Signs of Aging
☐ Facial fullness/Drooping
☐ Other: _____
☐ Sagging Skin
☐ Unwanted "stubborn" Fat
☐ Excess skin on Arms/Body
☐ Nose Size or Shape
☐ Size/Shape of Breasts
☐ Loose/Sagging thighs
☐ Dry/oily Skin
☐ Blotchiness/Discoloration
☐ Acne or Surgical Scars
☐ Appearance of Veins
☐ Lipstick Bleed
☐ Drooping Brows/Eyelids

Do you have any of these concerns:

☐ Fatigue/Fogginess ☐ Decreased Libido ☐ Weight Gain ☐ Hot Flashes ☐ Vaginal Laxity/Dryness
☐ Mood Swings ☐ Trouble Sleeping ☐ Thinning Skin ☐ Thinning Hair ☐ Facial Wrinkles

Products and services that may interest me now or in the future (please check all that apply):

☐ Facelift
☐ Necklift
☐ Browlift
☐ Blepharoplasty (Eyes)
☐ Leg/ Facial Veins
☐ Nose Reshaping
☐ Breast Reshaping
☐ CoolSculpting
☐ Botox/ Dysport
☐ Juvederm Filler Collection
☐ Fat Injections
☐ Skin Tightening
☐ Laser Treatments
☐ Facial Rejuvenation
☐ Ear Reshaping
☐ FemTouch
☐ Liposuction
☐ Tummy Tuck
☐ Arm Lift
☐ Skincare
☐ Aesthetic Treatments
☐ Permanent Makeup
☐ Tattoo Removal
☐ IV Nutrition Therapy

Challenges and obstacles:
What are the challenges that may prevent you from a procedure or treatment?

1. _____ 2. _____ 3. _____

I would like to receive correspondence via e-mail (newsletters, special events, promotions, etc.)

☐ **Yes** ☐ **No**