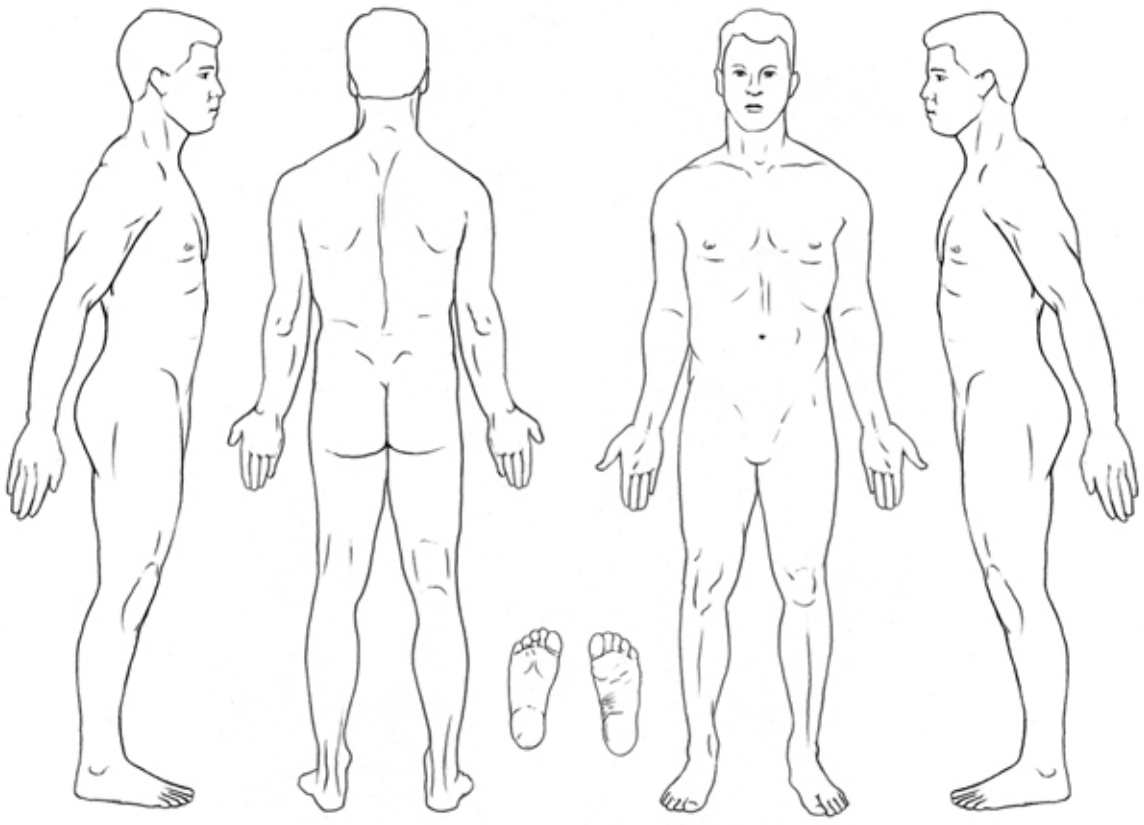
PERTH PHOTO-MEDICAL CENTRE
CELLULAR REJUVENATION & LASER LIGHT THERAPY

PERSONAL INFORMATION

Name: _____ Date of Birth: _____/____/_____
Address: _____
_____ Postcode: _____
Email address: _____
Best contact number: _____ Martital status: _____
Occupation: _____ No. of children: _____
Emergency contact name: _____ Phone: _____

How did you hear about us? _____

What is the main reason for consulting us today?
_____
_____
_____
_____



Please tick the box if you have, or have had any of the following:

YES

Allergies
- ☐ Seasonal/Hay Fever/Hives
- ☐ Sinus Congestion/Infections
- ☐ Foods
- ☐ Other:_____

Gastrointestinal
- ☐ Weight Loss/Gain
- ☐ Constipation Digestive complaints
- ☐ Other:_____

Endocrine
- ☐ Hormonal Imbalances
- ☐ Reproductive Problems
- ☐ Thyroid issues
- ☐ Diabetes
- ☐ Hypoglycemia (Low Blood Sugar)
- ☐ Other:_____

Head/Neurological
- ☐ Headaches
- ☐ Migraines
- ☐ Dizziness/Fainting
- ☐ Head Trauma/Concussion
- ☐ Epilepsy
- ☐ Stroke
- ☐ Other:_____

Immunological
- ☐ Chronic Infections
- ☐ Frequently Sick
- ☐ Swollen Glands/Sore Throats
- ☐ Frequent Travelling
- ☐ Bacterial/Viral/Fungal/Parasite
- ☐ Autoimmune disorders
- ☐ Other:_____

Females
- ☐ Pregnant
- ☐ PMS
- ☐ Menopausal/Pre-Meno/Peri-Meno
- ☐ Infertility
- ☐ Breast problems
- ☐ Other:_____

YES

Vascular/Cardiovascular
- ☐ Hypertension (High Blood Pressure)
- ☐ Hypotension (Low Blood Pressure)
- ☐ Irregular Heartbeat/Murmur/Palpitations
- ☐ Vascular Disease/Poor Circulation
- ☐ Heart or Chest Pain/Stroke
- ☐ Heart Surgery/Pacemaker
- ☐ Aneurysm/blood clots/DVT
- ☐ Heart Attack (MCI)
- ☐ Other:_____

Genitourinary
- ☐ Kidney/Bladder/Stones/Genitals
- ☐ Frequent Urination/UTI's
- ☐ Other:_____

Lymphatic/Haematological
- ☐ Anemia or other blood lab indicators
- ☐ Bleeding/Bruising Problems
- ☐ Oedema
- ☐ Unusual swelling in limbs or other
- ☐ Circulatory conditions
- ☐ Varicose Veins
- ☐ Other:_____

Musculoskeletal
- ☐ Arthritis/Joint Pain
- ☐ Muscle Pain/Aches
- ☐ Fractures/sprains/broken bones
- ☐ Metal screws/pins/foreign parts in body/joints
- ☐ Ligament or tendon injuries
- ☐ Body implants
- ☐ AS/OS/RA
- ☐ Other:_____

Eyes & Ears
- ☐ Loss of Vision/blurred vision/distorted vision/halos
- ☐ Light Sensitivity/photophobia
- ☐ Eye pain or soreness
- ☐ Loss of side vision/double vision/floaters
- ☐ Eye infections
- ☐ Dryness/redness/itching/burning
- ☐ Other:_____

Respiratory

- ☐ COPD
- ☐ Emphysema/chronic cough
- ☐ Smoker
- ☐ Other:_____

Skin/Integumentary/Dermatological

- ☐ Acne
- ☐ Psoriasis
- ☐ Eczema
- ☐ Burns
- ☐ Aging lines/wrinkles
- ☐ Keloids
- ☐ Scarring
- ☐ Other:_____

Other Issues

- ☐ Cancer
- ☐ Surgery
- ☐ Learning disability/ADD
- ☐ Depression
- ☐ Anxiety
- ☐ Excessive irritability
- ☐ Loss of Balance
- ☐ Sleep difficulties/Sleep Apnea/Insomnia
- ☐ Memory Issues
- ☐ Trauma
- ☐ Addictions
- ☐ STRESS
- ☐ Infectious conditions

If you have a condition/symptoms not listed, please explain:

_____
_____
_____

Please list all prescribed medications, including dosage and frequency:

_____
_____
_____

Please list all nutritional supplements, prescribed or OTC:

_____
_____
_____

I certifiy that the above information on this form is true and correct, to the best of my ability.

_____**Date:**_____
Patient Signature