



Dr. Ambrose Su, D.P.M
503.544.2794
www.thelasernailclinic.com

Patient Name: _____

Date of Birth: _____ Last _____ First _____ MI _____
Age: _____ Male _____ Female _____

Address: _____

City: _____ State _____ Zip _____

Phone: _____ Home _____ Cell _____ Work _____

How did you hear about our office? _____

Driver's License _____ E-Mail: _____

Emergency Contact: _____
Name Phone Number

Responsible Party (if applicable) _____

Employer: _____ Occupation _____

Previous Podiatrist: _____ Date Last Visit _____

Primary Care Physician: _____

Medical Conditions: _____

Medication Allergies (including topicals) _____

Current Medications: _____

Do You Have a History of Psoriasis? _____

Describe Any Previous Medical Treatments or Home Remedies; What Worked, What Failed

Have You Used Any of the Following:

- | | | |
|--------------------------|----------------------------|------------------------------|
| Lamisil Pills | Econazole/Spectazole Cream | Tinactin/Tolnafate Cream |
| Griseofulvin Pills | Lamisil Cream | Sporanox Pills |
| Micatin/Miconazole Cream | Terbinafine Pills or Cream | Lotrimin/ Clotrimazole Cream |

Patient/Responsible Party Signature

Date