

Medical History

Please help us assure you the highest quality care and safety by answering carefully.

Name _____

Male Female Age _____ HT _____ WT _____

Reason for Consultation _____

Personal Physician

Name of regular physician: _____ Specialty: _____

Business Telephone: (_____) _____ - _____ Date of last physical examination: _____

Medical

<i>Do you or have you had:</i>		Yes	No		Yes	No		Yes	No	
Anemia	<input type="checkbox"/>	<input type="checkbox"/>		Dry Eyes	<input type="checkbox"/>	<input type="checkbox"/>		Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>
Anesthesia Reaction	<input type="checkbox"/>	<input type="checkbox"/>		Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>		Liver Disease	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>		Fainting or blackouts	<input type="checkbox"/>	<input type="checkbox"/>		Lung Disease	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>		Fibromyalgia	<input type="checkbox"/>	<input type="checkbox"/>		Migraine Headaches	<input type="checkbox"/>	<input type="checkbox"/>
Back Pain	<input type="checkbox"/>	<input type="checkbox"/>		Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>		Peptic Ulcer	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding Tendency	<input type="checkbox"/>	<input type="checkbox"/>		Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>		Pneumonia	<input type="checkbox"/>	<input type="checkbox"/>
Blood clots/DVT	<input type="checkbox"/>	<input type="checkbox"/>		Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>		Shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>
Breast Cancer	<input type="checkbox"/>	<input type="checkbox"/>		Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>		Stroke	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>		Herpes simplex/fever blisters	<input type="checkbox"/>	<input type="checkbox"/>		Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>
Chest Pain	<input type="checkbox"/>	<input type="checkbox"/>		High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>		Vision Deficits	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>		HIV/Aids	<input type="checkbox"/>	<input type="checkbox"/>		Wheezing	<input type="checkbox"/>	<input type="checkbox"/>

If yes or other, please describe:

Surgical

Previous Operations

_____	Date _____	_____	Date _____
_____	Date _____	_____	Date _____
_____	Date _____	_____	Date _____

Current Medications

<i>Do you take:</i>	Yes	No		Yes	No	
Aspirin or Ibuprofen, NSAIDS	<input type="checkbox"/>	<input type="checkbox"/>		Vitamins & Herbal Supplements	<input type="checkbox"/>	<input type="checkbox"/>
Coumadin (Warfarin)	<input type="checkbox"/>	<input type="checkbox"/>		Steroids in the past year	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis Medicine	<input type="checkbox"/>	<input type="checkbox"/>		Retin A	<input type="checkbox"/>	<input type="checkbox"/>
Birth Control Pills	<input type="checkbox"/>	<input type="checkbox"/>		Accutane	<input type="checkbox"/>	<input type="checkbox"/>

List other medications you are currently taking:

Allergies

Medications: No Yes If Yes, please list: _____ Latex No Yes

Scarring

Have you formed excessive or unsatisfactory scars/keloids/hypertrophy in the past? Yes No

Family History

Is there a history of the following in your immediate family? If so, please list the family member beside the disease.

	Yes	No		Yes	No
Heart Disease _____	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes _____	<input type="checkbox"/>	<input type="checkbox"/>
Stroke _____	<input type="checkbox"/>	<input type="checkbox"/>	Cancer _____	<input type="checkbox"/>	<input type="checkbox"/>
Anesthesia Reaction _____	<input type="checkbox"/>	<input type="checkbox"/>	Bleeding Disorder _____	<input type="checkbox"/>	<input type="checkbox"/>

If other, please describe:

Personal History

Do you smoke? No Yes _____ packs per day. Do you drink alcohol? No Yes _____ per week.

For women only:

Have you ever been pregnant? No Yes If yes, # of pregnancies _____ # of children _____

Did you breast feed? No Yes Last Mammogram: _____ Date _____ Normal Abnormal