

# HARTSDALE MEDSPA

WEIGHT LOSS & LASER BODY CONTOURING

## HEALTH INFORMATION FORM

Date: \_\_\_\_\_

Name: \_\_\_\_\_

*Last*

*First*

Main reason for visit today: \_\_\_\_\_

**Have you or your close family members ever been diagnosed with: (check : ✓)**

	<i>Self</i>	<i>Family</i>
High Blood Pressure		
High Cholesterol		
Diabetes		
Heart problem		
Stroke		
Anemia		
Cancer		
Blood disease / clots		
Thyroid problem		
Liver problem / Hepatitis		

	<i>Self</i>	<i>Family</i>
T.B.		
Skin TB test (PPD) +		
Kidney problem		
Glaucoma		
Asthma / lung problem		
Epilepsy / Seizers		
Stomach Ulcer		
Osteoporosis		
Psychiatric problems		
Other problems		

**Are you suffering from:**

Unusual weight loss	
Chest pain / palpitations	
Easy bruising	
Excessive thirst / hunger	

Blood in sputum / urine / stool	
Shortness of breath	
Change in the bowel habits	
Excessive warm / cold feeling	

**Allergies:**

No known allergy to any medicine	
Known medicine and reactions	

Other important allergies

**Medicines that you take regularly: (including OTC and herbal meds)**

None

Name of the medicine

Strength

How many times a day


**Please mention Surgeries or Hospitalizations you had:**

None

Why?

Year

---

**Social history:**

Your education:

Your occupation:

Sexual preference:	Male / Female	No. of sex partners in your lifetime	Never had sex
Marital status:	Married    Single	Divorced                      Seperated	Window/Widower
Living Arrangement:	With family	Alone                      Together	
Do you smoke?	No / Yes	How much?	How long?
Do you take alcohol?	No / Yes	How much?	
Any illicit drug use?	No / Yes	Names:	
Blood transfusions:	No / Yes		
Tattoos/Body piercing	No / Yes	<u>(describe locations and images):</u>	

---

**Write down the year you had the following:**

Tetanus Vaccine	Pneumonia Vaccine	Hepatitis vaccine
Flu Vaccine	MMR vaccine	TB skin test
Stool blood test	Regular blood tests	Dental exam
Rectal Exam	Detailed eye exam	

**For Females:**

First date of your Recent Menstrual Period: \_\_\_\_\_

*Check following if true : ✓*

Pregnant	C Section	Hyserectomy
Post Menopausal	Birth control pills / Femals Harmones	IUD
Breast feeding	Tubal ligation	

No of abortions / miscarriages: \_\_\_\_\_ No. of births \_\_\_\_\_

Date of last Pap Smear: \_\_\_\_\_ Normal / Abnormal

Date of last mammogram: \_\_\_\_\_ Normal / Abnormal

Date of last Bone Density test: \_\_\_\_\_ Normal / Abnormal

**Note:** It is always advisable to choose a healthcare proxy who can make healthcare decisions on your behalf if you become unable to do so on your own. Please inform the doctor if you are interested in doing so. If you have any other health issues, please discuss with your doctor.

**Patient/Guardian's Signature:** \_\_\_\_\_

**Reviewing Physician:** \_\_\_\_\_