Bella Cosmedica

Patient Medical History

Patient Name: _____ Birthdate:_____ Age: _____ Sex: M / F Occupation:_____
Name of Physician: _____ Phone #: _____ Estimated date of last visit: _____
From whom or how did you learn of our practice? Name: _____
(family, friend, dentist, physician, phonebook, insurance, newspaper ad, Internet)

Please take the time to answer the following questions carefully. Thank you for helping us provide you with the safest care possible.

Have you ever had any serious illnesses, surgical procedures, hospitalizations? If yes, please explain: Y N

Have you ever had a serious complication from surgery such as a blood clot or excessive bleeding? Y N

Have you ever had liposuction or other cosmetic surgery? Y N
If yes, please explain:

Have you ever had surgery for weight loss? Y N
If yes, please explain:

Are you currently under the care of a physician? Y N
If yes, why?

List all medications you take.

List ALL vitamins or supplements you take.

Have you ever had injections of Botox, collagen or other dermal fillers? If yes, please specify. Y N

Are you currently or have you ever taken any of the following:
- Accutane Y N
- Aspirin or other blood thinners Y N
- Gold injections Y N
- MAO Inhibitors Y N
- Stimulant medications Y N

Are you allergic to or had a reaction to any of the following:
- Local Anesthetics (numbing medication) Y N
- Penicillin, Amoxicillin, or other antibiotic Y N
- Barbiturates, sedatives, etc. Y N
- Aspirin or Ibuprofen Y N
- Codeine or other pain killers Y N
- Latex or Rubber Products Y N
- Stimulant Medications Y N

Any other allergies? If yes, please explain. Y N

Have you ever had/experienced any of the following?
- Heart trouble Y N
- Heart attack Y N
- Heart murmur Y N
- Coronary artery disease Y N
- Angina (Chest Pain) Y N
- Palpitations Y N
- Heart surgery Y N
- Pacemaker Y N
- High or Low blood pressure Y N

Have you ever had rheumatic fever? Y N

Have you ever had a tumor or cancer that required radiation treatment or chemotherapy? Y N

Do you have a family history of cancer? Y N
If yes, what type?

Do you have inflammatory diseases such as arthritis, lupus or scleroderma? Y N

Do you have any blood disorders - such as anemia, leukemia, etc. Y N

Have you ever had any blood transfusions? Y N

Do you have any artificial joints, prosthesis or an artificial heart valve? (Please specify.) Y N

Have you ever bled excessively after being cut/hurt? Y N

Do you have any kidney problems? Y N

Do you have any liver problems or hepatitis? Y N

Do you have any type of lung disease? Y N

Do you have asthma? Y N

Are you diabetic? (borderline or otherwise) Y N

Do you have epilepsy or seizure disorders? Y N

Do you have nerve or muscle disorders such as myasthenia gravis or Lou Gherig's Disease? Y N

Do you have any thyroid disease? Y N

Do you have glaucoma? Y N

Do you or have you ever had an STD? Y N

Do you have a history of HPV? Y N

Do you have a history of Herpes or fever blisters? Y N

Are you HIV Positive or have AIDS? Y N

Have you ever had skin problems? Y N

Do you or have you ever had TB? Y N

Have you ever consulted a psychiatrist/psychologist? Y N

Have you ever had a problem with alcohol /drug addiction? Y N

Have you ever smoked? or used chewing tobacco? Y N
How much per day? How many years?

Do you drink alcoholic beverages? Y N
If yes, how much in one sitting? _____
how often? _____ how many years? _____

Have you used any type of social or controlled drug? Y N

Are you pregnant, suspect you may be, or trying to become pregnant? Y N

When was your last menstrual period? _____

When you sleep or lie down to rest, can you lie flat? Y N

Have you had sun exposure in the last month? Y N

Do you use a tanning bed or self-tanning lotion? Y N

Do you use sun-block or sunscreen regularly? Y N

How does your skin react to sun exposure? (circle one)
Burns easily never tans Burns easily tans rarely
Burns easily then tans Burns minimally tans easily
Rarely burns tans darkly Never burns always tans darkly

Have you ever tried to lose weight? If so, how? Y N

Has a physician ever suggested you lose weight? Y N

Have you ever seen a physician for weight loss or diet pills? Y N

Do you have any disease, condition or problem not listed? Y N
If so, please list.

Briefly describe the reason or concern that has brought you here for treatment: _____
_____

I have read and understood the above information, and certify that I have answered the questions correctly. I realize that providing inaccurate information could be dangerous to my health.

Signature _____