

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 any blood transfusions?	Y N
Have you ever had a serious complication from surgery such as a blood clot or excessive bleeding?	Y N	Do you have any artificial joints, prosthesis or an artificial heart valve? (Please specify.)	Y N
Have you ever had liposuction or other cosmetic surgery? If yes, please explain:	Y N	Have you ever bled excessively after being cut/hurt?	Y N
Have you ever had surgery for weight loss? If yes, please explain:	Y N	Do you have any kidney problems?	Y N
Are you currently under the care of a physician? If yes, why?	Y N	Do you have any liver problems or hepatitis?	Y N
List all medications you take.		Do you have any type of lung disease?	Y N
List <u>ALL</u> vitamins or supplements you take.		Do you have asthma?	Y N
Have you ever had injections of Botox, collagen or other dermal fillers? If yes, please specify.	Y N	Are you diabetic? (borderline or otherwise)	Y N
Are you currently or have you ever taken any of the following:		Do you have epilepsy or seizure disorders?	Y N
Accutane	Y N	Do you have nerve or muscle disorders such as myasthenia gravis or Lou Gherig's Disease?	Y N
Aspirin or other blood thinners	Y N	Do you have any thyroid disease?	Y N
Gold injections	Y N	Do you have glaucoma?	Y N
MAO Inhibitors	Y N	Do you or have you ever had an STD?	Y N
Stimulant medications	Y N	Do you have a history of HPV?	Y N
Are you allergic to or had a reaction to any of the following:		Do you have a history of Herpes or fever blisters?	Y N
Local Anesthetics (numbing medication)	Y N	Are you HIV Positive or have AIDS?	Y N
Penicillin, Amoxicillin, or other antibiotic	Y N	Have you ever had skin problems?	Y N
Barbiturates, sedatives, etc.	Y N	Do you or have you ever had TB?	Y N
Aspirin or Ibuprofen	Y N	Have you ever consulted a psychiatrist/psychologist?	Y N
Codeine or other pain killers	Y N	Have you ever had a problem with alcohol /drug addiction?	Y N
Latex or Rubber Products	Y N	Have you ever smoked? or used chewing tobacco?	Y N
Stimulant Medications	Y N	How much per day? How many years?	
Any other allergies? If yes, please explain.	Y N	Do you drink alcoholic beverages?	Y N
Have you ever had/experienced any of the following?		If yes, how much in one sitting? _____	
Heart trouble	Y N	how often? _____ how many years? _____	
Heart attack	Y N	Have you used any type of social or controlled drug?	Y N
Heart murmur	Y N	Are you pregnant, suspect you may be, or trying to become pregnant?	Y N
Coronary artery disease	Y N	When was your last menstrual period? _____	
Angina (Chest Pain)	Y N	When you sleep or lie down to rest, can you lie flat?	Y N
Palpitations	Y N	Have you had sun exposure in the last month?	Y N
Heart surgery	Y N	Do you use a tanning bed or self-tanning lotion?	Y N
Pacemaker	Y N	Do you use sun-block or sunscreen regularly?	Y N
High or Low blood pressure	Y N	How does your skin react to sun exposure? (circle one)	
Have you ever had rheumatic fever?	Y N	Burns easily never tans Burns easily tans rarely	
Have you ever had a tumor or cancer that required radiation treatment or chemotherapy?	Y N	Burns easily then tans Burns minimally tans easily	
Do you have a family history of cancer? If yes, what type?	Y N	Rarely burns tans darkly Never burns always tans darkly	
Do you have inflammatory diseases such as arthritis, lupus or scleroderma?	Y N	Have you ever tried to lose weight? If so, how?	Y N
Do you have any blood disorders - such as anemia, leukemia, etc.	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? If so, please list.	Y N
		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 _____	