MEDICAL HISTORY

Patient:_____ Date:_____ Page #1

Age:_____ Height:_____ Weight:_____
Are you allergic to any medications? ☐ Yes ☐ No If yes, list:_____

_____

List all medications that you are currently taking (including over-the counter non-prescription treatments, vitamins and herbal supplements):

_____

_____

Do you have now, or have your ever had diseases or conditions of: (Please check YES or NO)

LUNGS:	YES	NO
Bronchitis	☐	☐
Emphysema	☐	☐
Asthma	☐	☐
Chronic Cough	☐	☐
Tuberculosis	☐	☐
VASCULAR:		
High Blood Pressure	☐	☐
Chest Pain	☐	☐
Heart Attack	☐	☐
Irregular Heartbeat	☐	☐
Pacemaker	☐	☐
Blood Clot	☐	☐

Other Systemic:	Yes	No
Diabetes	☐	☐
Thyroid	☐	☐
Kidney	☐	☐
Bladder	☐	☐
Stomach	☐	☐
Bowel	☐	☐
Hepatitis or Liver Disease	☐	☐
Arthritis of Joint Deformity	☐	☐
Convulsions, Epilepsy, or Seizures	☐	☐
Eye, Ear, Nose, Mouth	☐	☐
Hay fever / Respiratory Allergies	☐	☐
Headaches	☐	☐
Psychological	☐	☐

Do you drink alcohol? ☐ Yes ☐ NO If YES, _____drinks per day

Have you ever had dental anesthesia (Novocain)? ☐ YES ☐ NO
If you would like to receive specials regarding cosmetic procedures, please provide you e-mail address:
e-mail: _____

SKIN:

When you are exposed to sun, do you:	☐	Tan only	☐	Tan and Burn ☐	Burn
Have you ever had skin cancer?	☐	YES	☐	NO	
Has anyone in your family had skin cancer?	☐	YES	☐	NO	
Has anyone in your family had eczema?	☐	YES	☐	NO	
Has anyone in your family had psoriasis?	☐	YES	☐	NO	
Do you have a history of any specific skin diseases?	☐	YES	☐	NO	

If yes, please list:_____
List any other disease or condition:_____
List surgical procedures you have had:_____

Please answer the following questions:

A. Do you smoke?	☐	YES	☐	NO	If yes, how much? _____
B. Do you bleed easily?	☐	YES	☐	NO	
C. (Women) Are you pregnant?	☐	YES	☐	NO	Due Date: _____
D. Do you have artificial joints?	☐	YES	☐	NO	

E. What is your occupation: _____