

MEDICAL HISTORY

PATIENT HEALTH HISTORY	YES	NO
Vascular Surgery		
Stroke		
Heart Attack		
High Blood Pressure		
Abnormal Heartbeat		
Diabetes		
Arthritis		
AIDS/ HIV+		
Asthma		
Depression		
Kidney Trouble or Stones		
Skin Cancer		
Bleeding Disorders		
Alcoholism		
Serious Injuries		
Eye Problems/ Injury		
Blood Clots		
Anemia		
Stomach Ulcers		
Hepatitis		
Thyroid Trouble		
Cancer		
Bleeding Tendencies		

List Other Medical Problems:

List Prior Cosmetic & Surgical Procedures (w/ approx. dates):

None

List all Pills, Medications and Herbs:

None

FAMILY HISTORY	YES	NO
Anesthesia Problems		
Stroke		
Heart Trouble		
High Blood Pressure		
Diabetes		
Mental Illness		
Kidney Trouble or Stones		
Cancer		
Bleeding Disorders		

Other: _____

SOCIAL HISTORY

Most Recent Occupation: _____

Retired

Married Single

Divorced Widowed

Student

Number of Children: _____

Smoking

Never Yes

Quit _____.

Smoke(d) _____ packs day _____ years.

Alcohol Use:

Never Occasional Daily

Currently Use or Had:

Retin-A

Accutane Botox

Collagen Renova

Chemical Peels

Allergies to Medicine:

None

REVIEW OF SYSTEM	YES	NO
Have you previously or do you:		
Scar Easily		
Bruise Easily		
ACCUTANE ®		
Cold Sores		
Daily Aspirin		
Keloids		
Facial Radiation		
Prior Healing Difficulty		
Loss of Hearing		
Prior Anesthesia Difficulty		
Contacts		
Glasses		
Dry Eye Problems		
Glaucoma		
Lasik		
Acid Reflux		
Shortness of Breath		
Chills or Fever		
Chest Pain		
Swollen Ankles		
Bridges or Dentures		
Daily Sun Exposure		
Stomach Problems		
Tanning Bed Use		
Phen / Fen for Weight Loss		
Blood Thinners		
Liquid Silicone Injections		
Migraine Headaches		
Seizures		
Anxiety		
Rashes		
Depression		
See a Mental Health Therapist		
Women Only:		
Birth Control Pills		
Possibility of Pregnancy?		
Nursing		
Hysterectomy		

How did you hear about us?

List your Primary Care Doctor and City:

Print Name:

Signature: _____	Date: _____
Age: _____	Sex: _____
HT: _____	Weight: _____