

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 you ever had diseases or conditions of: (Please check YES or NO)

LUNGS:	YES	NO	Other Systemic:	Yes	No
Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Kidney	<input type="checkbox"/>	<input type="checkbox"/>
Chronic Cough	<input type="checkbox"/>	<input type="checkbox"/>	Bladder	<input type="checkbox"/>	<input type="checkbox"/>
Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	Stomach	<input type="checkbox"/>	<input type="checkbox"/>
			Bowel	<input type="checkbox"/>	<input type="checkbox"/>
VASCULAR:			Hepatitis or Liver Disease	<input type="checkbox"/>	<input type="checkbox"/>
			Arthritis of Joint Deformity	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Convulsions, Epilepsy, or Seizures	<input type="checkbox"/>	<input type="checkbox"/>
Chest Pain	<input type="checkbox"/>	<input type="checkbox"/>	Eye, Ear, Nose, Mouth	<input type="checkbox"/>	<input type="checkbox"/>
Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>	Hay fever / Respiratory Allergies	<input type="checkbox"/>	<input type="checkbox"/>
Irregular Heartbeat	<input type="checkbox"/>	<input type="checkbox"/>	Headaches	<input type="checkbox"/>	<input type="checkbox"/>
Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>	Psychological	<input type="checkbox"/>	<input type="checkbox"/>
Blood Clot	<input type="checkbox"/>	<input type="checkbox"/>			

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: _____

