Medical History

PATIENT NAME______________________________ DATE OF BIRTH__________

Reason for Consultation:

____

Are you taking any medications including over the counter medications, vitamins, or herbal supplements?
If yes, please list:

____

____

Are you **allergic** to latex gloves, peanuts, shellfish or other foods? If yes,________________________
Are you **allergic** to any medications? If yes, list: ____

NAME OF FAMILY DOCTOR:
Name____________________________________
Address__________________________________
____
Phone____________________

NAME OF DOCTOR WHO SENT YOU:
Name____________________________________
Address__________________________________
____
Phone____________________

Was a biopsy performed for your current condition? If yes, when?________________________
Were X-rays, mammogram, sonogram, or C-T scan performed? If yes, when?_____________________

Do you smoke? If yes, how much_____________
Do you consume alcohol? If yes, how much____________
Do you use recreational drugs? __NO ___YES

Are you pregnant or breast feeding? __NO ___YES
Have you taken Accutane (Acne drug) in the past year? __NO ___YES
Have you had physical therapy or chiropractic treatment for your condition? ___NO ___YES

Have you ever had any injectable fillers (Botox, Restylane, Radiesse, Juvaderm)? ___NO ___YES

Height__________ Weight__________

SEE REVERSE SIDE..................

PATIENT NAME ________________________________

Please *CIRCLE* any of the following problems which you have now or have had in the past:

High Blood Pressure	Diabetes	Cancer	Blood transfusions
Heart disease	Thyroid Disease	Radiation therapy	Blood disorders
Heart attack	Emphysema	Chemotherapy	Excessive bleeding
Heart murmur	Chronic cough	Seizure disorder	Easy bruising
Angina	Asthma	Fainting or dizzy spells	Sinus problems
Heart surgery	Anemia	Orthopedic hardware	Psychiatric treatment
Bypass surgery	Glaucoma	Liver disease	Gastric bypass
Pacemaker	Hay fever	Hepatitis A,B,C	Other________________
Artificial heart valve	Chronic bronchitis	Rheumatic fever	____________________
Stroke	Pneumonia	Tuberculosis	

SURGICAL HISTORY

Please list all previous surgeries, surgeon's name and approximate date.

SURGERY	SURGEON	DATE
______________________________	____________________	___________
______________________________	____________________	___________
______________________________	____________________	___________
______________________________	____________________	___________
______________________________	____________________	___________

Surgical Experience:

Have you had any problems healing? __NO ___YES

Have you ever had keloids (very thick scars)? ___NO ___YES

Anesthesia Experience

Have you ever had general anesthesia? ___NO ___YES

Have you ever had any problems with anesthesia? ___NO ___YES

Do you need to pre-medicate before surgery or dental procedures? ____NO ___YES

All of the above is accurate and complete to the best of my knowledge.

Signature____ Today's Date___________

Revised 3/07