

Medical History

Patient Name _____ Date of Birth: _____

Reason for Consultation: _____

Are you **allergic** to any **medications**? If yes, list: _____

Are you **allergic** to **latex gloves, peanuts, shellfish or other foods**? If yes, _____

Please list any medications including over the counter medications, vitamins, or herbal supplements you are taking:

NAME OF REFERRING DOCTOR: _____ Phone# _____

NAME OF FAMILY DOCTOR: _____ Phone# _____

Please list any chronic medical conditions: _____

Do you smoke? Yes/No If yes, how much _____

Do you consume alcohol? Yes/No If yes, how much _____

Do you use recreational drugs? Yes/No

Have you taken Accutane (Acne drug) in the past year? Yes/No

Was a biopsy performed for your current condition? Yes/No If yes, when? _____

Have you had physical therapy or chiropractic treatment for your condition? Yes/No when? _____

Were X-rays, mammogram, sonogram, or C-T scan performed? Yes/No If yes, when? _____

If consult is for surgery, please complete: Height _____ Weight _____

If consult is for breast reduction surgery, please complete: bra size _____

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

Surgical Experience: Have you had any problems healing? NO YES

Have you ever had keloids (very thick scars)? 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 _____