Medical History

Name_________________________________ Date of Birth_____/_____/_____ Age_____________

Family Physician ____________________ Referring Physician ____________________ Date of last Physical Exam __________

What is the reason for your visit today? ____

Medical Conditions – Please ✓ if you currently have or have had in the past:

- ❑ AIDS/HIV POSITIVE
- ❑ ALCOHOLISM
- ❑ ANEMIA
- ❑ ARTHRITIS
- ❑ ASTHMA
- ❑ CANCER
- ❑ CHEMICAL DEPENDENCY
- ❑ CIRCULATION PROBLEMS
- ❑ DIABETES
- ❑ EPILEPSY
- ❑ GASTRIC REFLUX
- ❑ GLAUCOMA
- ❑ HEART CONDITIONS
- ❑ HEPATITIS
- ❑ HIGH BLOOD PRESSURE
- ❑ KIDNEY PROBLEMS
- ❑ LIVER PROBLEMS
- ❑ LUNG PROBLEMS
- ❑ MULTIPLE SCLEROSIS
- ❑ PACEMAKER
- ❑ PSYCHIATRIC CARE
- ❑ STOMACH ULCERS
- ❑ STROKE
- ❑ THYROID PROBLEMS
- ❑ TUBERCULOSIS
- ❑ OTHER ____________________

Surgery - Please ✓ if you have had:

- ❑ ABDOMINOPLASTY
- ❑ APPENDECTOMY
- ❑ BLEPHAROPLASTY (EYELIDS)
- ❑ BREAST AUGMENTATION
- ❑ BREAST RECONSTRUCTION
- ❑ BREAST REDUCTION/ LIFT
- ❑ C-SECTION
- ❑ D & C
- ❑ DENTAL EXTRACTONS
- ❑ FACELIFT
- ❑ FOREHEAD LIFT
- ❑ GALL BLADDER
- ❑ HEART BYPASS OR VALVE
- ❑ HERNIA
- ❑ HYSTERECTOMY
- ❑ LIPOSUCTION
- ❑ MASTECTOMY
- ❑ RHINOPLASTY
- ❑ TONSILLECTOMY
- ❑ TUBAL LIGATION
- ❑ OTHER ____________________

ANY PROBLEMS WITH:

- ❑ ANESTHESIA
- ❑ BLEEDING
- ❑ SCARRING

Medications:

PRESCRIPTION: ____

OVER THE COUNTER: Herbal supplements, vitamins, aspirin, ibuprofen, etc. ____________________

Allergies: medications, latex, food, environmental ____________________

Social Habits:

Tobacco
- ❑ Never
- ❑ Used to smoke
- ❑ Yes-How much?

Alcohol
- ❑ None
- ❑ Yes-How much?

With my signature, I confirm that the information provided is accurate and complete to the best of my knowledge. I authorize the release of any information including the diagnosis and records of examination or treatment rendered to me or the patient for whom I am signing during the period of such care to applicable insurance company(s) or other health practitioners.

Signature_________________________________ ______________________**Date**_______________

(Relationship to Patient)

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