

## Medical History

Patient name \_\_\_\_\_ Date of Birth \_\_\_/\_\_\_/\_\_\_\_\_

Height \_\_\_\_\_ft \_\_\_\_\_in      Weight \_\_\_\_\_pounds      Max. weight \_\_\_\_\_pounds

Do you have...

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> High blood pressure   | <input type="checkbox"/> Thyroid disease       | <input type="checkbox"/> Cancer                  |
| <input type="checkbox"/> Asthma/lung disease   | <input type="checkbox"/> Heart attack (MI)     | please specify: _____                            |
| <input type="checkbox"/> Heart disease/failure | <input type="checkbox"/> Depression/anxiety    | _____  |
| <input type="checkbox"/> Stroke                | <input type="checkbox"/> Bleeding problem      | <input type="checkbox"/> Hepatitis/liver disease |
| <input type="checkbox"/> Eye problems          | <input type="checkbox"/> Poor healing/scarring | <input type="checkbox"/> Kidney disease          |

Names and phone numbers of all physicians treating above conditions \_\_\_\_\_  
\_\_\_\_\_

Expand on any positive responses from above  
\_\_\_\_\_  
\_\_\_\_\_

If female:      date of last mammogram \_\_\_\_\_      Abnormal?      Y\_\_\_      N\_\_\_  
                    date of last Pap smear \_\_\_\_\_      Abnormal?      Y\_\_\_      N\_\_\_  
                    number of pregnancies \_\_\_\_\_      breastfed?      Y\_\_\_      N\_\_\_  
                    are you pregnant?      Y\_\_\_      N\_\_\_

List ALL medications you take, including any recently discontinued. Please include ANY over-the-counter, herbal or diet medications.

<u>Medication name</u>	<u>Dose/frequency</u>	<u>Medication name</u>	<u>Dose/frequency</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Have you been treated with Accutane (acne medication)?

Do you have any **allergies**?      Y\_\_\_      N\_\_\_

If so, list allergies here \_\_\_\_\_

Have you had surgery before?      Y\_\_\_      N\_\_\_

If so, please list:

<u>Date</u>	<u>Surgery</u>	<u>Surgeon name/phone number</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____

Do you smoke?      Y\_\_\_      N\_\_\_      Drink alcohol?      Y\_\_\_      N\_\_\_      How often \_\_\_\_\_

Do you use any drugs?      Y\_\_\_      N\_\_\_

I affirm that the above information is correct.

Patient (or guardian) signature \_\_\_\_\_      Date \_\_\_\_\_