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Patient Medical Health Form

Patient Name:_____ Age: _____ Date of Birth:_____

How were you referred to the office?_____

Reason for today's visit?_____

_____

Please list any history of major illnesses:_____

_____

Please list any prior surgeries with dates:_____

_____

Current Medications or Topical Creams with dosages including Aspirin, NSAIDs (i.e. Motrin, Advil & Alleve):__
_____

_____

_____

Allergies/Reactions to Medications, Anesthetics or Materials:_____

_____

Have you taken Accutane or anticoagulants in the last 6 months? ☐ NO ☐ YES When_____

Are you on Retin A,Tazorac, Avage, Differin? ☐ NO ☐ YES Dosage_____ Months_____

Are you pregnant or breastfeeding? ☐ NO ☐ YES

Do you have any permanent make-up, implants or tatoos? ☐ NO ☐ YES

Have you had any unprotected sun exposure, used tanning creams or tanning beds in the last 4-6 weeks? ☐ NO ☐ YES

Please answer each of the following questions by placing an (✓) in the "yes" box if your answer to the question is yes, or by placing an (✓) in the "no" box if your answer to the question is no. Fill in "who" and "when" information when necessary.

FAMILY HISTORY

Bleeding.....☐ NO ☐ YES _____
Anesthesia.....☐ NO ☐ YES _____
Medical Problems.....☐ NO ☐ YES _____
Other.....☐ NO ☐ YES _____

SOCIAL HISTORY

Tobacco.....☐ NO ☐ YES AMOUNT _____
Alcohol.....☐ NO ☐ YES AMOUNT _____
Drug Use.....☐ NO ☐ YES AMOUNT _____
Other.....☐ NO ☐ YES

REVIEW OF SYSTEMS

Are you currently, or have you had, problems with:

SKIN

Keloids..... ☐ NO ☐ YES
Herpes/Cold Sores..... ☐ NO ☐ YES
Skin Cancer/Precancerous lesion..... ☐ NO ☐ YES
Sun Exposure..... ☐ NO ☐ YES
Sunblock..... ☐ NO ☐ YES
Other..... ☐ NO ☐ YES

FACIAL

Hearing Loss..... ☐ NO ☐ YES
Nasal Obstruction..... ☐ NO ☐ YES
Sinusitis..... ☐ NO ☐ YES
Nasal Fracture..... ☐ NO ☐ YES
Sleep Apnea..... ☐ NO ☐ YES
Other..... ☐ NO ☐ YES

CARDIOVASCULAR

Heart Attack..... ☐ NO ☐ YES
Heart Murmur..... ☐ NO ☐ YES
High Blood Pressure..... ☐ NO ☐ YES
Other..... ☐ NO ☐ YES

NEUROLOGICAL

Depression/Anxiety..... ☐ NO ☐ YES
Migraine Headaches..... ☐ NO ☐ YES
Stroke/Paralysis..... ☐ NO ☐ YES
Head Injury..... ☐ NO ☐ YES
Neuromuscular Disorders..... ☐ NO ☐ YES
Other..... ☐ NO ☐ YES

ALLERGIC/IMMUNOLOGIC

Hay Fever/Seasonal Allergies..... ☐ NO ☐ YES
Cancer..... ☐ NO ☐ YES
Organ Transplant..... ☐ NO ☐ YES
Radiation Exposure..... ☐ NO ☐ YES
HIV..... ☐ NO ☐ YES
Other..... ☐ NO ☐ YES

MUSCULOSKELETAL

Arthritis..... ☐ NO ☐ YES
Fibromyalgia..... ☐ NO ☐ YES
Other..... ☐ NO ☐ YES

GASTROINTESTINAL

Indigestion or Heartburn..... ☐ NO ☐ YES
Acid Reflux..... ☐ NO ☐ YES
Hepatitis..... ☐ NO ☐ YES
Other..... ☐ NO ☐ YES

HEMATOLOGIC

Bleeding Disorder..... ☐ NO ☐ YES
Bruising..... ☐ NO ☐ YES
Transfusion..... ☐ NO ☐ YES
Other..... ☐ NO ☐ YES

ENDOCRINE

Diabetes..... ☐ NO ☐ YES
Thyroid Disease..... ☐ NO ☐ YES
Other..... ☐ NO ☐ YES

RESPIRATORY

Asthma..... ☐ NO ☐ YES
TB..... ☐ NO ☐ YES
Bronchitis..... ☐ NO ☐ YES
Emphesema..... ☐ NO ☐ YES
Other..... ☐ NO ☐ YES

CONSTITUTIONAL

Weight Gain..... ☐ NO ☐ YES
Weight Loss..... ☐ NO ☐ YES
Glasses/Contacts..... ☐ NO ☐ YES
Lasik/RK/PRK..... ☐ NO ☐ YES
Dry Eye..... ☐ NO ☐ YES
Other..... _____

GENITOURINARY

Dialysis/Kidney Failure..... ☐ NO ☐ YES
Other..... ☐ NO ☐ YES

AREAS OF CONCERN:

Fine Lines & Wrinkles..... ☐ NO ☐ YES
Major Lines- Nose & Mouth..... ☐ NO ☐ YES
Rough Texture of Skin..... ☐ NO ☐ YES
Tired Skin - Uneven Skin Tone..... ☐ NO ☐ YES
Brown/Red Spots..... ☐ NO ☐ YES
Spider Veins on Face..... ☐ NO ☐ YES
Appearance of Nose..... ☐ NO ☐ YES
Excess Skin around Eyes..... ☐ NO ☐ YES
Sagging Skin on Face..... ☐ NO ☐ YES
Appearance of Neck..... ☐ NO ☐ YES
Weak Chin..... ☐ NO ☐ YES
Protruding Ears..... ☐ NO ☐ YES

ARE YOU INTERESTED IN:

Rhinoplasty-nose reshaping..... ☐ NO ☐ YES
Blepharoplasty-eyelid surgery..... ☐ NO ☐ YES
Rhytidectomy-Face Lift..... ☐ NO ☐ YES
Forehead & Brow Lift..... ☐ NO ☐ YES
Mentoplasty-Chin Surgery..... ☐ NO ☐ YES
Otoplasty-Ear surgery..... ☐ NO ☐ YES
Botox..... ☐ NO ☐ YES
Facial Line Fillers..... ☐ NO ☐ YES
Skin Rejuvenation..... ☐ NO ☐ YES
Laser for Red/Brown Spots..... ☐ NO ☐ YES
Laser for Spider Veins/Angiomas..... ☐ NO ☐ YES
Laser for Hair Removal..... ☐ NO ☐ YES
Fractional Resurfacing..... ☐ NO ☐ YES
Medical Grade Products/Makeup..... ☐ NO ☐ YES
Microdermabrasion/ Chemical Peels... ☐ NO ☐ YES

The above information is accurate to the best of my knowledge.

_____Date_____
Signed Patient Name

If a minor or patient is unable to affix signature) Authority to sign consent:

_____Witness: ____ _____

Relationship:_____Date_____

I have reviewed the above information with the patient.

_____Date_____
Physician Signature